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ABSTRACT

In response to increasing demands for military child care and lack of comprehensive care standards, the Military Child Care Act of 1989 (MCCA) mandated improvements in military child care. Today, the Department of Defense runs a model child care system serving over 200,000 children daily at over 300 locations worldwide. Noting that most of the problems characterizing military child care before the MCCA abound in non-military child care today, this report examines the specific ways in which the military made significant improvements in its child care system. The report describes the military's approach to improving quality, keeping care affordable to parents, and expanding availability. Following a brief look at military child care before the MCCA, the report discusses the following key lessons for civilian child care: (1) It is possible to take a woefully inadequate system and dramatically improve it over a relatively short period of time; (2) To achieve progress, it is necessary to acknowledge the seriousness of the problem and the consequences of inaction; (3) Improve quality by establishing and enforcing comprehensive standards, assisting providers in becoming accredited, and enhancing provider compensation and training; (4) Keep parent fees affordable through subsidies; (5) Expand the availability of all kinds of care by continually assessing unmet need and taking steps to address it; and (6) Commit the resources necessary to get the job done. The report concludes by asserting that the lessons from the military child care system's experience convey a hopeful message to those seeking to improve child care across the United States. (KB)

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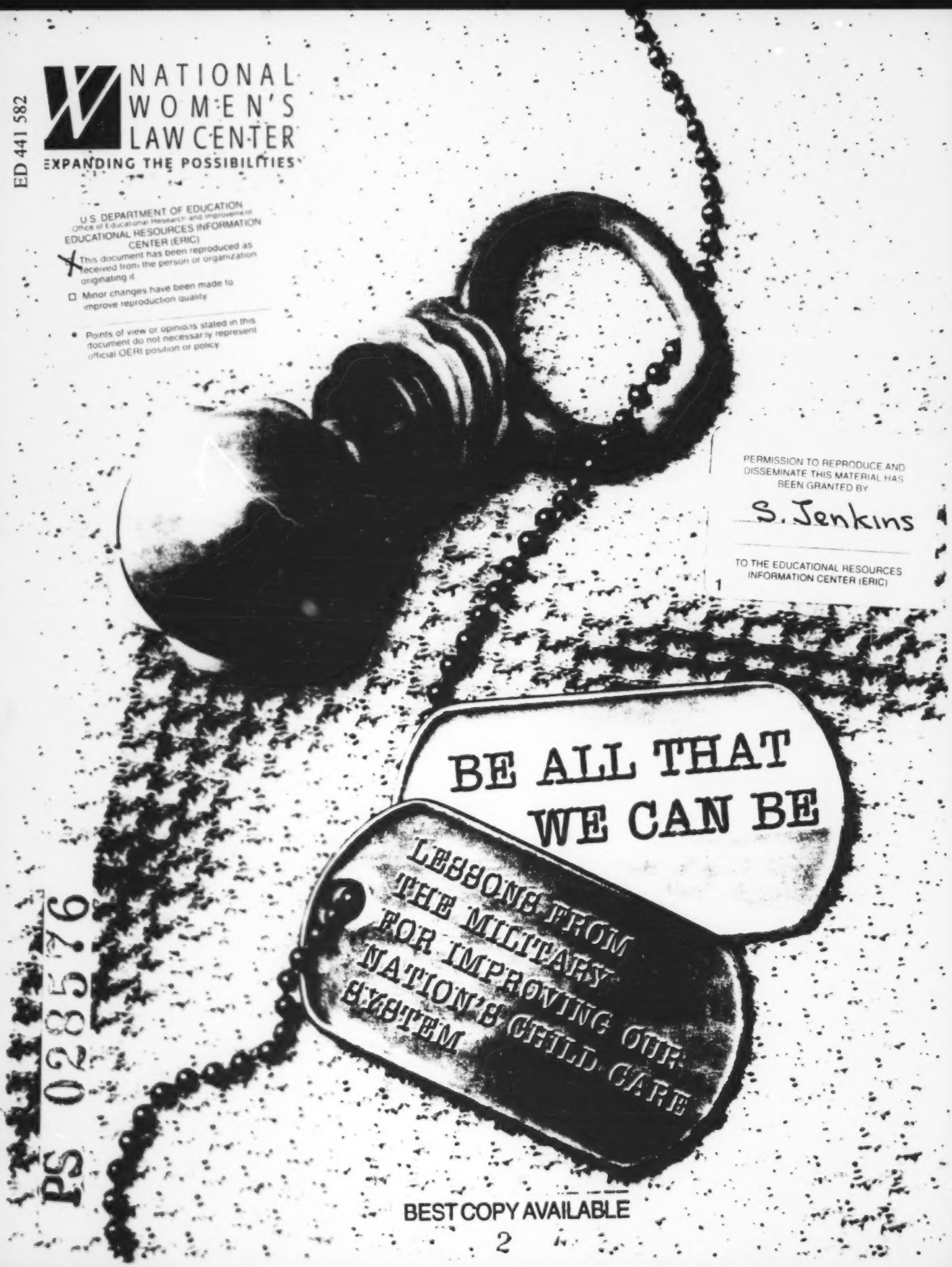

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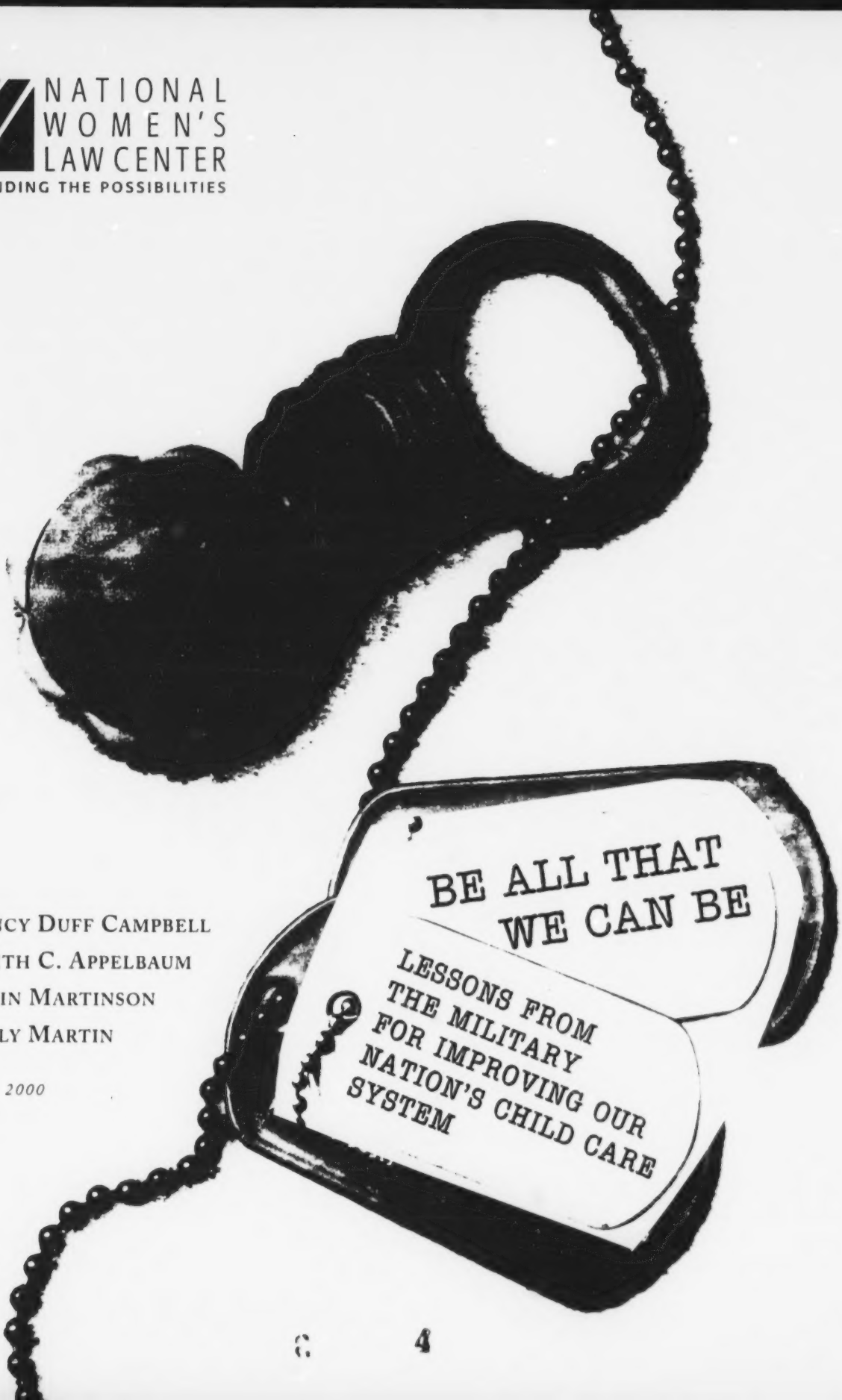

BE ALL THAT WE CAN BE

LESSONS FROM THE MILITARY FOR IMPROVING OUR NATION'S CHILD CARE SYSTEM

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April 2000

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I. INTRODUCTION AND OVERVIEW

Just ten years ago, the U.S. military's child care system suffered from a series of problems and deficiencies that will sound all too familiar to those concerned with the state of child care across the country today. Demand for child care had surged as a result of a changing military workforce that included increasing numbers of personnel with families, families with two working parents, and women. Tens of thousands of children were on waiting lists for care. Many facilities were unsafe or unsuitable. There were no comprehensive standards addressing maximum group size, appropriate activities, or other matters, and no rigorous inspection system for child care settings. Caregivers lacked training and were so poorly compensated—earning less than commissary shelf-stockers—that they did not stay long in the field; annual staff turnover rates at some child care centers were as high as 300 percent. Parent fees alone could not support the changes that were needed, and resource allocations from public funds were insufficient to make up the difference. Military child care was called a "disaster" by one military official[1] and the "ghetto" of American child care.[2] Senior U.S. Department of Defense (DoD) officials and Members of Congress expressed concern that, as a result of this state of affairs, the Services' workforce recruiting, motivation, productivity, and retention were suffering—and, consequently, military readiness was at risk.[3]

And then a remarkable thing happened. Prodded first by General Accounting Office (GAO) reports and Congressional hearings exposing the seriousness of the problems, and then by Congress' enactment of the Military Child Care Act of 1989 (MCCA)[4] mandating improvements in military child care, the military turned its system around. The Department of Defense now runs a military child care system that has been acclaimed—by numerous observers,[5] including the Commander in Chief[6]—as a model for the nation. Today, recognizing that child care is a workforce issue affecting the performance and readiness of the Armed Services,[7] the military runs what it calls the "largest employer-sponsored child care

1 Michelle Cottle, *A Tale of Two Centers*, Wash. Monthly, July 1, 1998, at 18.

2 Ann Crittenden, *Fighting for Kids*, Gov't Executive, December 1, 1997; Linda D. Kozaryn, *DoD Child Care: a Model for the Nation*, Am. Forces Press Service, April 1997.

3 *See Child Care Programs: Hearings Before the Military Personnel and Compensation Subcomm. of the House Comm. on Armed Servs.*, 100th Cong. 30 (1989) [hereinafter Child Care Hearings 1]; House Comm. on Armed Servs., National Defense Authorization Act for Fiscal Years 1990-1991, H.R. Rep. No. 101-121, at 307 (1989).

4 Department of Defense Authorization Act of 1989, Pub. L. No. 101-189, Title XV, 103 Stat. 1352, 1589-94 (codified as amended at 10 U.S.C. §§ 1791 to 1798 (1999)).

5 *See, e.g.*, Cottle, *supra* note 1; Crittenden, *supra* note 2; Kozaryn, *supra* note 2.

6 *See* White House Press Release, Memorandum for the Secretary of Defense (April 17, 1997).

7 *See* U.S. Department of Defense, *Military Child Development Program: DoD Child Care Model* (visited Jan. 14, 2000) <http://dticaw.dtic.mil/milchild/model.html>.

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program in the country," serving over 200,000 children daily at over 300 locations worldwide, in child development centers (CDCs), family child care homes (FCCs), and before- and after-school programs.[5] More impressive than the sheer scale of the system, however, is its success in offering a comprehensive approach that, according to a variety of analyses and accounts, provides high-quality, affordable care.

Today, in the Military Child Development Program:

- The military uses a systematic approach that links centers, family child care homes, before- and after-school programs, and resource and referral services to assist parents in finding care through a single point of entry.
- Basic standards—encompassing health and safety, staff/child ratios, staff training, and other matters—have been established and are rigorously enforced in all settings (centers, family child care, and school-age programs). Ninety-five percent of all military child care centers also meet the higher national accreditation standards of the National Association for the Education of Young Children (NAEYC)—addressing both structural elements of care (*e.g.*, staff/child ratios, caregiver training, available space and equipment) and interactive elements (*e.g.*, staff/child and staff/parent interactions, developmental activities)—compared with just 8 percent of non-military centers nationwide.
- In military child development centers, caregivers receive systematic, ongoing training, and increased compensation that is linked to their training. Staff turnover has been reduced dramatically, from over 300 percent annually at some bases to less than 30 percent, and staff morale and professionalism have improved.

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- Parent fees in military child development centers are subject to a sliding fee schedule based on income to ensure that personnel with the lowest incomes can afford child care; on average, fees for such care are some 25 percent lower than fees paid by civilians for center-based care.
- The hourly cost per child of providing high-quality care in military child development centers is not substantially different from the cost of providing high-quality care in comparable civilian centers.
- While there is still considerable unmet demand, the system is serving a steadily increasing proportion of military personnel who need it. Over 200 new centers were built between 1985 and 1998. The military estimates that it currently meets 58 percent of the projected need for care (by offering over 173,000 spaces), and its goal is to meet 80 percent by 2005.

Many of the same problems that characterized military child care before the MCCA abound in non-military child care today: high-quality care is too often unaffordable or simply not available to families who need it. The result is a double standard of child care, where, as one child advocate put it, "the best chance a family has to be guaranteed affordable and high-quality care in this country is to join the military."[9] The military's experience therefore raises an obvious set of questions for those concerned about shortcomings in the availability, quality, and affordability of child care for families across the country. How did the Armed Services achieve their "about face" on child care? What lessons can be learned from this transformation?

This report is an effort to answer those questions. After a brief look at military child care before the MCCA, the report examines in some detail the specific ways in which the military made significant improvements in its child care system. It describes the military's approach to improving quality, keeping care affordable for parents, and expanding availability. Most importantly, it provides lessons on how similar improvements might be made in civilian child care.

Briefly summarized, the key lessons are as follows.

First, those seeking to make improvements in civilian child care should not be daunted by the task: the military has shown by its example that it is possible to take a woefully inadequate child care system and dramatically improve it over a relatively short period of time. If even a tradition-bound institution like the military can turn its child care system around, similar progress should be achievable in other settings.

Second, to achieve progress, it is necessary to acknowledge the seriousness of the child care problem and the consequences of inaction. Policy makers in Congress and the Department of Defense acted to reform military child care after extensive Congressional hearings and GAO reports not only exposed the poor state of military child care, but also documented two results: because the child care system was failing to meet the needs of a changing workforce it was jeopardizing workforce performance (and thus military readiness), and it was affecting the welfare of the children. Similar concerns about the unavailability of high-quality, affordable child care across the U.S. today—its impact on workforce performance, and the effects on the healthy development and learning of children—should prompt action to improve civilian child care.

9 Crittenden, *supra* note 2 (quoting Helen Blank, Director of Child Care Programs and Policy, Children's Defense Fund).

Third, the *quality* of child care can be improved by focusing on establishing and enforcing comprehensive standards, assisting providers in becoming accredited, and enhancing provider compensation and training. The military has developed comprehensive standards that providers must meet in order to be certified to operate, and it ensures that these standards are met through a system of unannounced inspections and serious sanctions for failure to comply. It also assists providers in meeting the additional requirements necessary to become accredited by a nationally recognized program. It encourages parental involvement through parent boards, an "open door" policy, and an anonymous hotline for reporting problems. And it has increased provider compensation and training, and linked compensation increases to the achievement of training milestones. While some states have taken steps forward in one or more of these areas, on the whole the states have been far less effective in addressing these issues, and could benefit substantially from emulating the military's formula for success.

Fourth, child care *affordability* should be addressed through a system of subsidies. The military child care system keeps care affordable for parents through the use of a sliding schedule of fees based on parent income, as well as other subsidies. As a result, the average weekly fee paid by military families for center-based care is significantly lower than the average weekly fee paid by civilian families for such care. In the civilian world, a patchwork array of government measures assists some families in meeting their child care expenses, but these policies are inadequate. Policy makers at both the federal and state levels should follow the military's example in making more resources available—as well as using the mechanisms it has used to distribute these resources—to help subsidize care for families who cannot afford to pay the full cost of good child care.

Fifth, the *availability* of care should be expanded. Although demand still far exceeds supply in the military system, the military has made significant progress in this regard by continually assessing unmet need and taking steps to address it through a comprehensive approach that includes all kinds of care: child care centers, family child care, and before- and after-school programs, as well as resource and referral agencies to assist parents in locating care. Some states and localities have taken a variety of steps to expand the supply of child care, but the military's experience demonstrates, among other things, that it is essential to measure unmet demand and then develop a plan for meeting it with specific goals and timetables.

Sixth, improving the quality, affordability, and availability of child care is a costly proposition, and will succeed only if policy makers commit the resources necessary to get the job done. Through increased Congressional appropriations and allocations from within DoD resources, the funds provided for military child care have been climbing dramatically in recent years, making the turnaround in military child care possible. The same commitment of resources on the civilian side is not yet evident. An increased public investment is critical if the same progress is to be achieved in civilian child care.

The military's experience shows, in short, that policy makers can be prodded into action by the acknowledgment of a serious child care problem, and that once they make child care a top priority and allocate the resources that are needed to address it, a seriously deficient system can be turned around. Those faced with the challenge of expanding access to affordable, high-quality child care across the United States today—policy makers, child care administrators, advocates, providers, parents, and others—should find encouragement in this conclusion. Inspired by the military's example, and armed with knowledge of the tools it used to it achieve its successes, they need only to apply the lessons learned to make child care for all working families, like the child care provided to military families—to echo the Army's familiar jingle—"be all that it can be."

II. THE NEED FOR CHANGE— MILITARY CHILD CARE BEFORE THE MILITARY CHILD CARE ACT

For many years, child care services in the military were provided through parent cooperatives or projects of wives' clubs or other private organizations. This system was loosely structured and had few regulations; it operated mainly on an hourly basis as a babysitting service.[10] By 1978, DoD had issued a directive recognizing child care as an official Morale, Welfare, and Recreation activity, leaving it up to the individual Services to develop their own program policies and standards, and up to individual installations, if they provided child care services, to establish their own operating procedures.[11] But in the 1980s, a series of GAO reports and Congressional hearings and reports revealed that military child care was seriously deficient in several important respects.

Lack of capacity to meet the needs of a changing workforce

In the period after the Vietnam War, the military experienced significant demographic changes that had a direct impact on the demand of military personnel for child care. With the advent of the All Volunteer Force in 1973, the Services were no longer composed mainly of single men, and were required to compete for personnel in the civilian economic marketplace. Increasingly, Service members were career-oriented personnel with dependents. By 1985, about 60 percent of enlisted personnel in all Services were married, about 43 percent were married with children, and about 3 percent were single parents.[12] Seventy-five percent of officers were married, 60 percent were married with children, and 2 percent were single parents.[13] Overall, 55 percent of all active-duty military personnel (enlisted and officers combined) were married.[14]

Moreover, in the 1970s and 1980s, the number of women in the Services increased as a result of societal changes that saw more women in the workforce as a whole, as well as an increased emphasis on recruiting women into the Armed Services as fewer qualified men sought to sign up.[15] Between 1973 and 1989, the percentage of active-duty enlisted women jumped from just over 2 percent to almost 11 percent,[16] and the percentage of active-duty

10 *See* David F. Burrelli, Congressional Research Serv., Military Child Care Provisions: Background and Legislation 2 (1995).

11 *See* U.S. General Accounting Office, Report to the Secretary of Defense, Military Child Care Programs: Progress Made, More Needed 1 (1982) [hereinafter GAO 1982].

12 *See* U.S. General Accounting Office, Report to Congressional Requesters, Military Child Care: Extensive, Diverse, and Growing 32 (1989) [hereinafter GAO 1989].

13 *See id.*

14 *See* Military Family Resource Center, Profile of the Military Community: 1998 Demographics 19 (1998). In 1998, 56 percent of active-duty military members were married, down from a high of 61 percent in 1994. *see id.*; 47 percent of all military members (not only active-duty members) had children, *see id.* at 29-30. Nearly 8 percent of all military members were single parents in 1998. *See id.*

15 *See* Burrelli *supra* note 10, at 2.

16 *See* David F. Burrelli, Congressional Research Serv., Women in the Armed Forces 14 (1995). This trend has continued. By 1998, approximately 14 percent of active-duty enlisted Service members were women. See Military Family Resource Center, *supra* note 14, at 6.

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female officers almost tripled, from 4 percent to just over 11 percent.[17] As the number of women in the military increased, the number of dual-military couples also increased.[18]

Military officials noted these changes in Congressional hearings in 1988 and 1989. Defense Department officials testified that about 44 percent of military spouses were in the labor force, and that there were 50,000 active-duty single parents and 55,000 dual-military couples.[19] The number of families needing child care varied by Service, but an Air Force official testified that over 60 percent of the Air Force was married and 70 percent of Air Force families had children at the ages that required child care. For them, he said, "having this service available at a reasonable cost is no longer nice to have; it's a necessity."[20]

These changes increased the pressure on the child care system. Navy officials testified that many child care centers had waiting lists of several hundred children and operated too few hours to meet military parents' needs.[21] The GAO reported that, across the Services, nearly 25,000 children were on waiting lists for center care—and this did not take into account parents at the 247 installations who would have been interested in center care had it been available.[22]

17 See Burrell, *supra* note 16, at 14. In 1998, nearly 14 percent of active-duty officers were women. See Military Family Resource Center, *supra* note 14, at 6.

18 See Burrell, *supra* note 10, at 2.

19 *See Hearings on National Defense Authorization Act for Fiscal Year 1990: Hearing to Review Military Quality of Life before the Readiness Subcomm. of the House Comm. on Armed Services*, 101st Cong. 1467 (1989) [hereinafter *Child Care Hearings 1*]. In 1998, just over 6 percent of Service members were in dual-military marriages, and of those dual-military married couples, 42 percent had children. See Military Family Resource Center, *supra* note 14, at 18, 29. According to DoD, currently 65 percent of military spouses work outside the home. See U.S. Department of Defense, Military Child Development Program Frequently Asked Questions (visited Jan. 14, 2000) <http://[illegible]> [hereinafter DoD Frequently Asked Questions].

20 *Child Care Hearings 1*, *supra* note 3, at 12 (testimony of Eric M. Thorson, Deputy Assistant Secretary for Manpower Resources and Military Personnel, U.S. Air Force). Today, active-duty military personnel have 1.2 million minor children. Four hundred eighty-five thousand of these children are under six, and 911,000 of them are under 12. See Linda Smith, Director of U.S. Department of Defense Office of Family Policy, Presentation to Defense Advisory Committee on Women in the Services at U.S. Department of Defense (Feb. [illegible], 2000).

21 *See Child Care Hearings 2*, *supra* note 19, at 1569.

22 See GAO 1989, *supra* note 12, at 13-14.

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Unsafe and unsuitable facilities

A 1982 GAO report found that many military installations had child care centers that were not suitable for the purpose and did not even meet fire, health, and safety standards.[23] It noted that a 1980 study of the Army had found that over 70 percent of child care centers then in use did not meet fire and safety codes.[24] The conditions that were identified at some centers included lead-based paint peeling from the walls and ceilings, and leaking roofs in such poor condition that repairs were not feasible.[25] At one installation, a child care center housed in old barracks adjacent to stables suffered from pest control problems and a sinking kitchen floor.[26]

Reports of child abuse

In 1986, allegations of widespread sexual abuse of children at the child care center at the Presidio Army base in San Francisco came to light. Representative (now Senator) Barbara Boxer from California brought these reports to the attention of the House Armed Services Committee, which made child abuse at military centers a focus of Congressional hearings. The hearings disclosed that the military child care system lacked adequate child abuse prevention and detection mechanisms.[27]

Lack of adequate standards or inspections

According to the 1982 GAO report, there were no DoD-wide comprehensive standards for military child care, and those issued by the individual Services were inadequate in addressing issues such as maximum group size, educational activities, and staff training.[28] Using as a benchmark the Federal Interagency Day Care Requirements that had been established in 1968 for federally funded child care programs,[29] the GAO found that military child care fell far short. For instance, military centers had no limits on total group size and often had groups two or three times the recommended size; thus, while the recommended caregiver/child ratio for infants and toddlers was 1:4, in Air Force centers the ratio was 1:15.[30] Moreover, there was no rigorous system of inspections (the Marine Corps had no inspections at all) or sanctions for failing inspections.[31] In addition, the GAO found that none of the Services had regulations that adequately specified the equipment, materials, toys, games, and books that should be supplied to provide developmental opportunities, or the staff and supervision necessary for an effective development program.[32]

Untrained, undercompensated staff; high staff turnover

The Services did not provide adequate training for caregivers and other center staff, according to the 1982 GAO report.[33] In addition, Congressional hearings highlighted the difficulties in recruiting and retaining providers, in large part due to low salaries and poor working conditions. Army officials testified, for example, that the hourly wage for caregivers in child care centers in 1988 was $4.68, compared with installation trash collectors at $6.65 and commissary shelf-stockers at $8.05.[34] Other reports found caregivers complaining that wages and working conditions were better at Burger King than in military child care

23 *See* GAO 1982, *supra* note 11, at 5-6.

24 *See id.* at 5.

25 *See id.* at 6.

26 *See id.*

27 *See Child Care Hearings 1, supra* note 3, at 103 *et seq.*; *see also* H.R. Rep. No. 101-121, at 308 (1989).

28 *See* GAO 1982, *supra* note 11, at 10.

29 The Federal Interagency Day Care Requirements were developed in 1968 to provide minimum program standards and regulations for operating federally funded child care programs, but were subsequently suspended in a series of Congressional actions and regulatory moratoriums and ultimately repealed by the U.S. Department of Health and Human Services. *See* 47 Fed. Reg. 7668 (1982).

30 *See* GAO 1982, *supra* note 11, at 11.

31 *See* Gail L. Zellman & Anne S. Johansen, RAND National Defense Research Institute, Examining the Implementation and Outcomes of the Military Child Care Act of 1989, 79 (1998).

32 *See* GAO 1982, *supra* note 11, at 11.

33 *See id.* at 16.

34 *See Child Care Hearings 1, supra* note 3, at 32.

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centers, and noted that no efforts were made to treat caregiving as a career track.[35] As a result, centers could not successfully compete for the best employees—which meant they suffered from turnover rates as high as 300 percent at some bases[36] and were sometimes forced to retain poorly performing personnel.[37]

Inability of parents to pay for care

Military parents could not afford to pay more for child care than they were paying—especially since the principal users of military child care centers were lower-ranking enlisted personnel, many of whom were supporting more than one child.[38] Moreover, at least in the view of some Members of Congress, child care had not traditionally fared well within the Pentagon in the allocation of resources,[39] which had caused parent fees to increase substantially.[40]

The array of problems—adding up to a shortage of affordable, quality child care—presented a serious workforce issue for the military. As one Army official testified before Congress:

> Like our counterparts in the corporate world, we have found that child care is a major force issue. Lack of availability of quality child care impacts on productivity and is an increasing factor in work absenteeism and tardiness.[41]

A report of the House Armed Services Committee summarized:

> [C]hild care is an important readiness and retention issue for military families: readiness because single parents and dual service couples must have access to affordable and quality child care if they are to perform their jobs . . . ; retention because family dissatisfaction with military life—and particularly the inability of many spouses to establish careers or obtain suitable employment—is a primary reason trained military personnel leave the service.[42]

35 *See* Zellman & Johansen, *supra* note 31, at 53.

36 *See* U.S. General Accounting Office, Report to Congressional Requesters, Child Care: How Do Military and Civilian Center Costs Compare? 9 (1999) [hereinafter GAO 1999]; U.S. Department of Defense, *Military Child Development Program: Training and Wages* (visited Jan. 18, 2000) <http://dticaw.dtic.mil/milchild/training.html> [hereinafter *Training and Wages*].

37 *See* Zellman & Johansen, *supra* note 31, at 53.

38 *See* H.R. Rep. No. 101-121, at 307-8 (1989).

39 *See Military Child Care: Hearing Before the Military Personnel and Compensation Subcomm. of the House Comm. on Armed Servs.*, 101st Cong. 68 (1989) [hereinafter *Child Care Hearings 3*].

40 A House Armed Services Committee report noted that although child care programs were eligible to receive up to 70 percent appropriated funds, they received only approximately 30 percent during fiscal years 1987 and 1988; because the balance had to come principally from parent fees, fees had increased substantially. *See* H.R. Rep. No. 101-121, at 307.

41 *Child Care Hearings 1*, *supra* note 3, at 30.

42 H.R. Rep. No. 101-121.

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III. THE RESPONSE— THE MILITARY CHILD CARE ACT AND SUBSEQUENT REFORMS

A. ENACTMENT OF THE MCCA

The Congressional hearings and reports, GAO reports, and other reviews of military child care during the 1980s culminated in the enactment of the Military Child Care Act of 1989.[43] Representative Beverly Byron, Chair of the Military Personnel and Compensation Subcommittee of the House Armed Services Committee, who had presided over the hearings, described the bill that became the MCCA as an attempt to pull together solutions to the problems that had come to light and "to give the military child care system a much needed and long overdue shot in the arm."[44]

The goal of the MCCA was to improve the quality, availability, and affordability of military child care.[45] The Act specifically included provisions addressing the creation of new child care staff positions,[46] training and compensation of child development center employees,[47] employment of training and curriculum specialists,[48] inspections,[49] child abuse prevention and safety measures,[50] parent fees based on family income,[51] and other issues. On some issues, the statute prescribed specific measures in some detail (such as at least four unannounced inspections of each center every year and sanctions for violations of health or safety regulations), and on others Congress directed DoD to prescribe regulations to be applied uniformly across the Services, leaving the details to DoD (such as content of safety and operating procedures and a schedule of parent fees).[52]

In addition, the MCCA directed DoD to make additional appropriated funds available to each Service for child care.[53] In so doing, Congress intended to "send a strong signal to the Department of Defense that child care is and will continue to be a top priority for the foreseeable future and that the DoD should treat it as such for funding purposes."[54]

43 Department of Defense Authorization Act of 1989, Pub. L. No. 101-189, Title XV, 103 Stat. 1352, 1589-94 (codified as amended at 10 U.S.C. §§ 1791 to 1798 (1999)).

44 *Child Care Hearings 3*, *supra* note 39, at 1 (comments of Rep. Beverly B. Byron, Chairman, Military Personnel and Compensation Subcommittee, House Armed Services Committee).

45 *See* Zellman & Johansen, *supra* note 31, at xvii.

46 *See* Title XV, 103 Stat. at 1592.

47 *See id.* at 1591-92.

48 *See id.* at 1591.

49 *See id.* at 1593.

50 *See id.*

51 *See id.*

52 *See id.* at 1589-94.

53 *See id.* at 1590.

54 H.R. Rep. No. 101-121, at 308.

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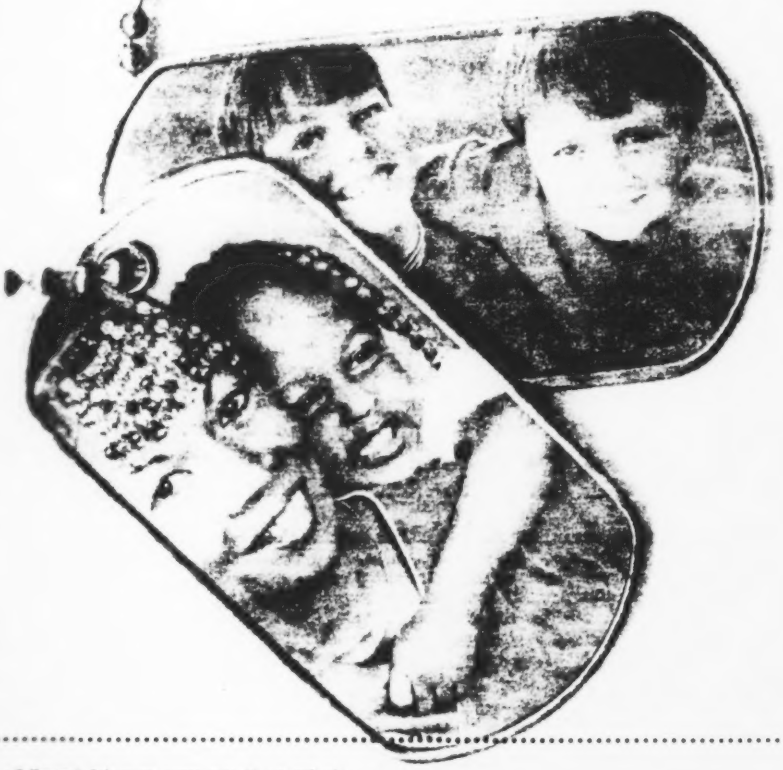
B. THE TURNAROUND IN MILITARY CHILD CARE

The discussion below examines the changes that were made following enactment of the MCCA in the areas of quality, affordability, and availability of child care. It is drawn from several sources, including the Congressional Research Service; the General Accounting Office; DoD materials; interviews with the Director of DoD's Office of Family Policy, Linda Smith; and a study of the implementation of the MCCA performed by the RAND Corporation. The RAND study, which was sponsored by DoD, relied on a worldwide mail survey of 245 military child development center program managers, face-to-face interviews with 175 individuals at DoD and on seventeen installations, and a review of over 300 relevant military documents.[55]

The MCCA focused primarily on improving the child care provided through CDCs on military bases for children age six weeks to age twelve, and much of the discussion in this report relates to changes that were made in care provided at CDCs as a result of the MCCA. Today, about 37 percent of the children participating in the military child development program are in center-based care, in about 800 centers world-wide whose hours of operation are upwards of twelve hours a day.[56] The military also provides care in FCCs, where over 9,000 military spouses or family members care for a small number of unrelated children in the provider's own government quarters,[57] sometimes on a twenty-four-hour



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55 *See* Zellman & Johansen, *supra* note 31, at xviii-xix.

56 *See* Office of Family Policy, U.S. Department of Defense, *Child Development System Size* (2000) [hereinafter *Child Development System Size*]; GAO 1999, *supra* note 36, at 8. Most of the centers serve children ages six weeks to five years, with about 45 percent of children served under age three. *See id* at 8.

57 *See* U.S. Department of Defense, *Information Paper: Department of Defense (DoD) Child Development System* (April 2000). FCCs are also very occasionally housed on civilian property. *See* Interview with Linda Smith, Director, U.S. Department of Defense Office of Family Policy, in Washington, D.C. (Mar. 24, 2000).

basis.[58] About 32 percent of the children participating in military child care are in FCCs.[59] The military also provides before- and after-school and holiday/summer programs for children in kindergarten through age twelve in youth centers, CDCs, schools, chapels, and other installation facilities;[60] about 25 percent of the children participating in military care are in these programs.[61] An additional 6 percent of participating children receive resource and referral services or some form of temporary child care services.[62] Eligibility for all military child care is on a first-come, first-serve basis without regard to rank, although commanders have the authority to give preference to particular individuals or types of individuals to meet military needs.[63]

1. RAISING THE QUALITY OF CARE

Improving the quality of child care provided to military families was a central objective of the MCCA. This section describes the program features outlined by the MCCA and implemented by DoD to improve child care quality—primarily in the CDCs—and provides evidence of the effectiveness of these efforts in achieving this goal. There were several facets to this effort: a certification and inspection process, a program accreditation system, and measures to improve staff quality, including policies to increase caregiver wages and training.

a. Improving Accountability: An Inspection and Certification System

A critical element of the effort to improve the quality of military child care was the adoption of a set of measures to hold child care providers accountable for meeting certain standards. After the MCCA, DoD established uniform certification standards that all CDCs were required to meet, developed mechanisms to determine whether these standards were in fact met, and enforced sanctions for failure to meet them.[64] Previously, as noted above, no comprehensive set of standards had been applied across all divisions of the military, inspections were not rigorous, and often there were no sanctions for failure to improve.[65]

The MCCA does not specifically set standards for military child care centers. It does, however, require DoD to prescribe regulations on CDC safety and operating procedures, to be applied uniformly across all of the Services.[66] The MCCA also establishes a stringent CDC inspection and enforcement process requiring:

- Unannounced inspections of CDCs at least four times a year.[67]
- The immediate remedying of any violation of a safety, health, or child welfare law or regulation, and the remedying within ninety days of any non-life-threatening violations—with immediate closure of the center if these deadlines are not met (although there is a provision allowing waivers from the closure requirement if, for example, major facility reconstruction is required).[68]
- Prior to 1996, a report to Congress of any closures of CDCs due to violations.[69]

58 Single parents and dual-military couples in particular often need extended care during deployments.

59 *See Child Development System Size*, *supra* note 56. FCCs serve children newborn to age 12, including children who are sick or have special needs. *See* U.S. Department of Defense, *Military Child Care Program: Family Child Care* (visited Mar. 16, 2000) <http://dticaw.dtic.mil/milchild/fcc.html> [hereinafter *Family Child Care*].

60 *See* Smith, *supra* note 20.

61 *See Child Development System Size*, *supra* note 56.

62 *See id.*

63 *See* Smith, *supra* note 20.

64 In response to the 1982 GAO report, DoD began work to improve military child care standards even before the MCCA was enacted, further refining and finalizing them subsequent to its passage. *See* Interview with Linda Smith, *supra* note 57.

65 *See* Zellman & Johansen, *supra* note 31, at 79.

66 *See* 10 U.S.C. § 1794(d) (1999).

67 *See* 10 U.S.C. § 1794(e) (1999).

68 *See* 10 U.S.C. § 1794(f) (1999).

69 *See* Department of Defense Authorization Act of 1989, Pub. L. No. 101-189, Title XV, 103 Stat. 1352, 1594, *repealed by* National Defense Authorization Act for Fiscal Year 1996, Pub. L. No. 104-106, ch. 88, § 568, 110 Stat. 186, 335.

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- Establishment of a task force to respond to child abuse allegations, and creation and maintenance of a national child abuse and safety hotline.[70]

In response to these legislative mandates, DoD developed a set of standards that all CDCs are required to meet.[71] Child development centers that pass inspections based on these standards receive a DoD certificate of operation for one year, which is equivalent to a state license.[72] The standards established by DoD govern facility requirements, staff/child ratios, staff training and qualifications, child abuse prevention procedures, funding, parent participation, and health and sanitation.[73] Designed to ensure that a minimum level of quality is met, these standards are considered by DoD to be equivalent to "the middle range" of state licensing standards.[74]

A critical feature of the system is the implementation of the MCCA's inspection and sanction requirements. Three of the four required inspection visits are carried out by installation personnel, with the results reported to the installation commander.[75] This includes at least one comprehensive health and sanitation inspection, one comprehensive fire and safety inspection, and a third inspection conducted by a multidisciplinary team.[76] The fourth inspection is conducted by someone at a high level of command with expertise in early childhood development.[77] This inspection includes a review of compliance with the DoD standards on staff/child ratios, training curriculum, and the safety of indoor and outdoor equipment.[78] Parent interviews are conducted periodically as part of the inspection process.[79] In addition, DoD staff periodically conduct their own unannounced inspections.[80] Once all the inspections are completed, the inspectors produce a certification report with ratings in each of thirteen categories, on a four-point scale (representing compliance, partial compliance, noncompliance, and not applicable).[81] If the report confirms that the CDC is operating in compliance with military standards, DoD recertifies the center for another year.[82]

The MCCA establishes severe consequences for failing an inspection, through a policy known as "fix, waive, or close."[83] CDCs are required to fix any violations within the time frames specified in the statute (immediately, or within ninety days for a non-life-threatening violation), obtain a waiver of the requirements, or face closure.[84] Military personnel report that the CDCs take the inspection process very seriously, and promptly remedy any

70 *See* 10 U.S.C. § 1794(a), (b) (1999).

71 *See* U.S. Department of Defense, Instr. 6060.2, *Child Development Programs (CDPs)* (January 19, 1993) [hereinafter Instr. 6060.2].

72 *See* Burelli, *supra* note 10, at 19.

73 *See* Instr. 6060.2, *supra* note 71.

74 Military Child Care Program, U.S. Department of Defense, *Oversight* (visited Mar. 16, 2000) <http://dticaw.dtic.mil/milchild/oversght.html> [hereinafter *Oversight*]. This view is based on an analysis of the Services' standards by the Logistics Management Institute (LMI), after improvements were made to them in response to the 1982 GAO report. *See* Interview with Linda Smith, *supra* note 57. The LMI concluded that, except in two areas, the standards "f[e]ll in the middle range of the state standards." Robert L. Crosslin & Trevor L. Neve, Logistics Management Institute, Acceptable and Affordable Child Care Services for Military Families, at 2-1, 2-4 (1988). Thereafter, DoD, as part of its post-MCCA development of uniform standards, improved the standards in these two areas—space requirements for outdoor play areas and caregiver/toddler ratios. Each year DoD reviews the standards to ensure that they continue to fall at least in the middle range of state standards. See Interview with Linda Smith, *supra* note 57.

75 *See* Zellman & Johansen, *supra* note 31, at 79, 82-83.

76 *See id.* at 79-80.

77 This individual must meet the validator qualifications required by the National Association for the Education of Young Children. *See id.* at 80.

78 *See id.*

79 *See id.*

80 *See id.*

81 *See id.* at 81-82.

82 *See id.* at 60; *see generally Oversight*, *supra* note 74.

83 *Oversight*, *supra* note 74.

84 *See* 10 U.S.C. § 1794(f) (1999).

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violations.[85] No centers have been closed since 1992, and waivers are rarely requested or granted.[86]

An important aspect of the inspection and certification process is the high level of visibility given to the certification results. Commanders of the military installations are routinely briefed on the results of the child care inspections at their installations.[87] The RAND study found that this visibility helps ensure that the installation commander makes the necessary resources available to make improvements after a negative inspection report.[88]

While standards for FCC homes and school-age care are not addressed by the MCCA, DoD requires these providers to meet similar certification requirements.[89] Standards for FCC providers and school-age care programs cover provider qualifications, staff/child ratios, health and safety, enrollment procedures, and provider staff training.[90] Additionally, FCC homes and school-age care programs are monitored for compliance with the applicable standards. Family child care homes receive quarterly unannounced inspections and are monitored monthly by a family child care director who works at the base.[91] School-age programs are subject to at least one comprehensive and one unannounced inspection annually.[92]

Overall, the inspection process and the enforcement of certification standards have been critical to the military's efforts to improve child care quality. The director of the military child care program called this the "single most important" aspect of the program[93] and the RAND report characterized the effect of the inspection requirements as "immediate and dramatic," in that the closure of several CDCs produced a flurry of activities—repairs, renovations, purchases of equipment—designed to avoid additional closures.[94] Two aspects of the inspection process are central to its success: because the inspections are unannounced, providers must be in compliance with the standards on a day-to-day basis, and there are high-profile, serious consequences for noncompliance.[95]

Defense Department personnel also regard the hotline established pursuant to the MCCA—which allows parents to call administrators directly and anonymously to report problems—as critical to their enforcement efforts.[96] Because it can be difficult for parents to come forward with information about abuse, this hotline has been crucial to identifying problematic centers; in fact, it was information provided via the hotline that led to the closure of some facilities in the early 1990s.[97]

b. Obtaining Program Accreditation

In addition to the inspection and certification procedures, a key element in the military's effort to develop and maintain quality child care is its accreditation system. In order to become accredited, CDCs are required to meet a set of specific standards in addition to those required for certification, and to have compliance confirmed by an outside validator.

85 *See* Interview with Linda Smith, Director, U.S. Department of Defense Office of Family Policy, in Arlington, Va. (April 15, 1999).

86 *See id.*

87 *See* Zellman & Johansen, *supra* note 31, at 95.

88 *See id.*

89 *See* Interview with Linda Smith, *supra* note 85. The standards for CDCs and FCCs cover many of the same areas, but are tailored to reflect the differences in settings. For instance, CDCs and FCCs have different standards governing maximum group size and staff/child ratios, as well as evacuation procedures and outdoor equipment requirements. *See id.*

90 FCC providers, for example, receive training in identifying, monitoring, and reporting child abuse; first aid; child development; fire, safety, and health procedures; child guidance techniques; and business practices. *See Family Child Care*, *supra* note 59. See Instr. 6060.2, *supra* note 71, at Enclosure 8, for FCC standards and U.S. Department of Defense, Instr. 6060.3, *School-Age Care (SAC) Program* (December 19, 1996), for school-age care standards.

91 *See Family Child Care*, *supra* note 59. The inspections cover fire, safety, health, and program. *See id.*

92 *See* GAO 1999, *supra* note 36, at 12.

93 Interview with Linda Smith, *supra* note 85.

94 Zellman & Johansen, *supra* note 31, at 90-91.

95 *See* Interview with Linda Smith, *supra* note 85.

96 *See id.*

97 *See id.*

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The MCCA did not initially require DoD to develop an accreditation process for all centers. Rather, to develop understanding of the benefits and costs of accreditation, the MCCA required that at least fifty military CDCs be accredited by an "appropriate national early childhood accrediting body."[98] These centers were to serve as a demonstration program from which other centers could learn about best practices.[99] Because of the positive experience with accreditation, however, the MCCA was later amended to require all CDCs to meet the established accreditation standards, and CDC compliance with the standards is now checked during the DoD inspection process.[100] While there are no specific penalties for failing to meet the standards for accreditation, centers that do not meet them are provided additional assistance to improve in those areas in which they are found lacking.[101]

The accreditation process contains some similarities to the certification process, but is distinct in two ways. First, while the certification process relies on the military's own set of standards, the accreditation process provides validation from an outside organization based on nationally recognized measures of child care quality. DoD selected for this purpose the National Association for the Education of Young Children, an organization of early childhood professionals that has established a set of professional quality standards based on a comprehensive review of the available literature on child development and child care quality and the judgment of early childhood specialists.[102]

Second, while some of the NAEYC accreditation criteria are similar to those required for DoD certification, the NAEYC requirements go beyond the certification requirements to provide explicit guidance concerning matters such as staff/child interactions, staff/parent interactions, and developmentally appropriate activities.[103] In addition, the accreditation standards are more specific and prescriptive regarding curriculum content and environmental features.[104] NAEYC's standards and accreditation process have earned wide respect among experts in the field, and accreditation by NAEYC is recognized as a standard for good practice.[105]

Achieving accreditation requires completion of a three-step process that includes a self-study, site validation, and a commission decision.[106] In the self-study, CDC caregivers rate their own classrooms and teaching activities, and survey CDC staff and parents, guided by an early childhood classroom observation scale.[107] When the self-study is completed, a validation visit is conducted to verify the results.[108] A three-person accreditation commission, consisting of a diverse group of early childhood professionals, reviews all materials and

98 Department of Defense Authorization Act of 1989, Pub. L. No. 101-189, Title XV, § 1508, 103 Stat. 1352, 1595.

99 *See id.*

100 *See* National Defense Authorization Act for Fiscal Year 1996, P.L. 104-106, Div. A, Title V, § 568(a)(1), 110 Stat. 186, 335 (codified at 10 U.S.C. § 1797 (1999)). DoD did not meet the MCCA's deadline of accreditation of 50 CDCs by June 1, 1991, but implementation improved over time, and by 1996, when the MCCA was amended to require accreditation, nearly all Air Force CDCs had been accredited, and the other Services had improved their accreditation records as well. *See* Zellman & Johansen, *supra* note 31, at 147-48.

101 *See* Interview with Linda Smith, *supra* note 85.

102 NAEYC, through its National Academy of Early Childhood Programs, administers a national, voluntary, professionally sponsored accreditation program for all types of child care centers as well as preschools, kindergartens, and school-age care programs. *See* NAEYC, *Accreditation* (last modified Aug. 19, 1999) <http://www.naeyc.org/accreditation/default.asp>.

103 *See* Interview with Linda Smith, *supra* note 85.

104 *See id.*

105 *See* Mary L. Culkin et al., National Conference of State Legislatures, Building Blocks: A Legislator's Guide to Child Care Policy 18 (1997). Several studies have found a correlation between NAEYC accreditation and higher quality care. *See* Scott Groginsky et al, National Conference of State Legislatures, Making Child Care Better: State Initiatives 24 (1999). For more information on the NAEYC accreditation process and criteria, see NAEYC, Accreditation Criteria and Procedures of the National Association for the Education of Young Children (1998).

106 *See* Zellman & Johansen, *supra* note 31, at 145.

107 *See id.*

108 *See id.*

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decides either to grant a three-year accreditation or to defer it.[109] Department of Defense personnel are not involved in the site validation or commission decision.[110]

When RAND studied the military's accreditation experience, it found, through a survey of child development directors and interviews with CDC staff and parents, that accreditation had several positive effects:

- *More child-initiated and child-controlled activities.* Analysis of caregiver interactions during the self-study revealed inappropriate activities on the part of caregivers who had a tendency to be too directive. The accreditation process resulted in more child-initiated and child-controlled activities as well as activities better suited to particular age groups.[111]
- *Higher staff morale and pride.* The prestige of accreditation and the recognition for having met a nationally recognized standard led to improvements in staff morale.[112]
- *Acquisition of better equipment, both indoors and out, as well as improved learning centers.* The NAEYC requirements led many CDCs to upgrade or replace the equipment they used.[113]
- *Better-defined goals.* The self-study resulted in a more defined mission regarding the provision of child care. The NAEYC criteria helped focus staff on key aspects of child care delivery, such as staff/child interactions.[114]
- *More culturally diverse curriculum.* The self-study completed for the NAEYC accreditation often revealed that the CDC curriculum was not culturally diverse. As a result of the accreditation process, books that portray diverse cultures, multiracial dolls, and the celebration of cultural holidays were included.[115]

Today, more than 95 percent of military CDCs are accredited, and DoD's goal is to achieve accreditation of 100 percent of the CDCs in the year 2000.[116] In contrast, only 8 percent of child care centers in the United States have been accredited by NAEYC.[117] Because of DoD's positive experience in CDC accreditation, it is now in the process of determining how a similar accreditation process can be employed for its FCCs.[118]

c. Focusing on Staff Compensation and Training

Another key element of the military's effort to improve child care quality was its emphasis on increasing staff compensation and training at the CDCs. Based on the requirements established by the MCCA, several steps were taken in this area, including raising caregiver compensation and linking increased wages to training; developing a comprehensive training program; and hiring training and curriculum specialists.

Higher wages, linked to training

During the development of the MCCA, the low pay of caregivers and resulting high rates of turnover were frequently cited as major problems in the military's child care system. The Defense Department estimates that before passage of the MCCA, annual CDC staff turnover at some individual installations was as high as 300 percent, which resulted in poor-

109 *See id.* at 145-46.
110 *See id.* at 144-46.
111 *See id.* at 153-54.
112 *See id.* at 155-56.
113 *See* Zellman et al., RAND National Defense Research Institute, Examining the Effects of Accreditation on Military Child Development Center Operations and Outcomes 23 (1994).
114 *See* Zellman & Johansen, *supra* note 31, at 154.
115 *See id.* at 153.
116 *See* Interview with Linda Smith, supra note 85; Smith, *supra* note 20.
117 *See* U.S. Department of Defense, *Military Child Development Program: Partnerships* (visited Jan. 18, 2000) <http://dticaw.dtic.mil/milchild/partner.html> [hereinafter *Partnerships*].
118 *See* Interview with Linda Smith, *supra* note 85.

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quality care.[119] To address these issues, the MCCA requires that the rates of pay for CDC workers be equivalent to rates of pay for other employees at the same installation with comparable training, seniority, and experience.[120] To ensure sufficient funding to increase wages, the MCCA also originally required that parent fees be used exclusively for CDC caregiver wages (and not for supplies or administrative expenses, which were to be covered by appropriated funds).[121]

In anticipation of passage of the MCCA, a DoD task force was established to examine the appropriate wages for CDC workers in light of the wages of other, comparable employees on military bases.[122] After a three-month study, the task force concluded that a GS-2 was the appropriate comparator for an entry-level child care worker with a high school education, and DoD developed a pay scale that began at this level.[123]

The Defense Department went a step further than the MCCA mandate by requiring salary increases to be tied to the completion of training milestones. This requirement was intended to ensure that higher pay would result in a higher quality and more stable workforce.[124] Child development center caregivers start at the equivalent of a GS-2 and are raised to a GS-3 salary level after six months of in-service training.[125] They then have eighteen months to complete an additional, comprehensive training program (see details below), whereupon they achieve full competency and receive an automatic pay increase to a GS-4 level.[126]

Today, under this system, a CDC caregiver with a high school diploma starts at nearly $8 per hour (approximately $16,660 annually), receives an increase after six months of training to $8.71 per hour, and upon successful completion of training receives nearly $10 per hour ($20,800 annually).[127] Child care workers with some supervisory responsibility and the nationally recognized Child Development Associate (CDA) credential begin at nearly $11 an hour ($22,800 annually) and top-level CDC directors can earn as much as $26 an hour ($54,000).[128] Both full-time and part-time staff also receive life insurance, health insurance, sick leave, and retirement benefits—generally providing an additional value equal to 22 percent of their salary.[129] Staff turnover at military CDCs is now below 30 percent annually, according to DoD.[130]

The RAND study found that the military's caregiver wage policy had a number of positive effects on CDC staff quality and helped achieve the goals of a better-trained and more stable caregiver workforce.[131] The RAND analysts confirmed that wages increased from

119 *See* GAO 1999, *supra* note 36, at 9; *Training and Wages*, *supra* note 36; Interview with Linda Smith, *supra* note 85.

120 *See* 10 U.S.C. § 1792(c) (1999).

121 *See* Department of Defense Authorization Act of 1989, Pub. L. No. 101-189, Title XV, § 1502(b), 103 Stat. 1352, 1590, *repealed by* National Defense Authorization Act for Fiscal Year 1996, Pub. L. No. 104-106, ch. 88, § 568, 110 Stat. 186, 335. This requirement was repealed in 1996 as no longer necessary. Although parent fees are still used exclusively for CDC caregiver wages, appropriated funds are also used for this purpose. *See* Interview with Linda Smith, *supra* note 57.

122 *See* Interview with Linda Smith, *supra* note 85.

123 *See id.*

124 *See* Zellman and Johansen, *supra* note 31, at 51.

125 *See* Interview with Linda Smith, *supra* note 57.

126 *See* Interview with Linda Smith, *supra* note 85.

127 *See* U.S. Office of Personnel Management, *2000 Locality Schedule General Rates of Pay for Rest of U.S., Effective January 2000* (visited Mar. 31, 2000) <http://www.opm.gov/oca/2000tbls/GShrly/html/GSHRRUS.HTM>; Interview with Linda Smith, *supra* note 57. Moreover, caregivers at this level with experience can receive as much as $12.71 an hour; these pay scales are additionally subject to locality increases and annual inflation adjustments. *See* U.S. Office of Personnel Management, *supra*; Interview with Linda Smith, *supra* note 57.

128 *See* U.S. Office of Personnel Management, *supra* note 127.

129 *See* M.A. Lucas, *Military Child Care: A Staff Development and Compensation Initiative for Caregiving Personnel*, National Center for the Early Childhood Work Force Compensation Initiatives Bulletin, Jan. 1995, at 6.

130 *See Training and Wages*, *supra* note 36. DoD notes that much of the current turnover is explained by the fact that 75 percent of child care staff are spouses of military members, who move approximately every three years. *See Frequently Asked Questions*, *supra* note 19.

131 *See* Zellman & Johansen, *supra* note 31, at 53-59.

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pre-MCCA levels and turnover was reduced significantly,[132] and found that the wage program provided a strong incentive for staff to complete the training and "weeded out" less motivated caregivers. Military CDC program managers who responded to a RAND survey generally agreed that the caregiver wage program resulted in improvements in the education and experience level of caregiver applicants, and indicated that the program was successful in achieving its ultimate goal: a better-trained, more stable workforce.[133]

Family child care providers are independent contractors and, accordingly, are not directly compensated by the military.[134] However, the MCCA authorizes the use of appropriated funds to provide subsidies to FCC providers "so that family home day care services can be provided to members of the Armed Forces at a cost comparable to the cost of services provided by child development centers."[135] These subsidies, which are at the discretion of the installation commander, include direct cash subsidies to providers—in effect a "compensation subsidy." The RAND report found that, except in the Army, commanders had been reluctant to pay providers direct cash subsidies[136] and recommended greater use of such subsidies, based on the evidence that where they have been used they have increased the supply and reduced the cost of FCC care to parents.[137] Since the RAND report, the Navy and the Marine Corps have joined the Army in employing such subsidies, decreasing the cost to parents and increasing the number of FCC homes on their installations.[138]

Components of staff training

The MCCA requires DoD to establish a training program for CDC employees and to apply it uniformly in all divisions of the military.[139] The statute requires satisfactory completion of the training program as a condition of employment.[140] The training must, at a minimum, cover early childhood development, activities and disciplinary techniques appropriate to children of different ages, child abuse prevention and detection, and cardiopulmonary resuscitation and other emergency medical procedures.[141]

The Defense Department developed a comprehensive training program based on the statutory requirement, and covers all the costs of the program.[142] All caregivers receive the training, regardless of experience or skill level.[143] The training program is competency-based, and skills must be demonstrated in the child care setting.[144] The training modules follow the functional areas of the CDA credential program, and consist of the following components.[145]

- *Orientation training.* Caregivers in military CDCs must complete six to eight hours of orientation training before they work with children. This covers topics such as child abuse identification, reporting, and prevention; first aid; health and sanitation; child guidance techniques; age-appropriate activities; and parent and family relations.[146]

132 The RAND study found that the average annual turnover rate, across the Services, was 48 percent pre-MCCA and decreased to under 24 percent by 1993, four years after passage of the MCCA. *See id.* at 56-58.

133 *See* Zellman & Johansen, *supra* note 31, at 55-56.

134 *See Family Child Care*, *supra* note 59.

135 10 U.S.C. § 1796 (1999).

136 *See* Zellman & Johansen, *supra* note 31, at 139. In contrast, indirect subsidies, such as the provision of liability insurance or toys and equipment, are common. *See id.* at 140.

137 *See id.* at 138-139, 141. The RAND report noted, for example, that an Army subsidy of $150 per month, per child had, in one major command, increased infant and toddler slots by 43 percent. *See id.* at 138.

138 *See* Interview with Linda Smith, *supra* note 85.

139 *See* 10 U.S.C. § 1792 (1999).

140 *See id.*

141 *See id.*

142 This training program was developed by Teaching Strategies, Inc., an internationally recognized publisher of early childhood and curriculum materials. Teaching Strategies' products are used extensively in Head Start, child development, preschool and child care programs.

143 *See* Interview with Linda Smith, *supra* note 85.

144 *See Training and Wages*, *supra* note 36.

145 *See id.*

146 *See id.*

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- *Core competency training.* Providers are then required to complete fifteen training modules, which follow the functional areas of the CDA credential program. Caregivers complete the modules for the age group they supervise and work through the modules at their own pace with the support of a trainer. Training is conducted in small groups, through classroom demonstrations, and in one-on-one settings. Caregivers must complete the training within two years of being hired, and as discussed above, receive a pay increase when they do so.[147]

- *Annual training.* After the initial training is completed, caregivers are required to participate in an additional twenty-four hours of training each year. Working with the trainer, they develop an annual training plan, which includes refresher training on child abuse identification, reporting, and prevention; safety; health; and developmental program updates.[148]

This focus on training has improved child care quality. Overall, 95 percent of the CDC program managers surveyed in the RAND study reported some or significant improvements in the quality of child care resulting from the implementation of the MCCA staff training requirements.[149] The RAND analysts found that, together with higher wages, better training has instilled a sense of professionalism in many caregivers; some use the required training to complete the CDA credential, which is required by a range of child care programs and the Head Start program.[150]

Moreover, because of DoD's success with the training program for the CDCs, it now requires that FCC and school-age providers receive comparable training, with federal resources covering the cost. Family child care providers must complete basic orientation training before providing care, a core training program of fifteen modules geared to the FCC setting, and twenty-four hours of refresher training each year.[151] The FCC training is similar to that received by CDC caregivers, but also covers nutrition, business operations, and child development environments.[152] Caregivers for the school-age program must complete thirty-six hours of training based on the competency modules within the first year of work, as well as twenty-four hours of refresher training annually.[153]

Training and curriculum specialists

Another important aspect of the effort to improve staff quality was the creation of a staff position to focus exclusively on issues relating to training and curriculum. The MCCA requires the placement of at least one such specialist in each CDC and specifies that these individuals—who are required to have "appropriate credentials and experience"—are responsible for special teaching activities at the center, daily oversight and instruction of other child care employees at the center, daily assistance in the preparation of lesson plans, assistance in the center's child abuse prevention and detection program, and advising the director on the performance of other child care employees.[154] The Defense Department requires the training and curriculum specialists to have expertise in child development issues, with a minimum of a BA in early childhood education or child development and experience working with young children in a group, or a graduate degree in early childhood education or child development.[155]

147 *See id.*; Interview with Linda Smith, *supra* note 57.

148 *See id.*

149 *See* Zellman & Johansen, *supra* note 31, at 103.

150 *See id.* at 59. The CDA credential also allows them to compete for higher-paid supervisory positions in military CDCs. *See* Interview with Linda Smith, *supra* note 57.

151 *See Family Child Care*, *supra* note 59.

152 *See* Interview with Linda Smith, *supra* note 85. She has described this as including "training to the need;" for example, if an installation has a need for 24-hour, extended care for up to two weeks, FCC providers are trained in specific aspects of this type of care, such as the need to secure powers of attorney for the children. Smith, *supra* note 20.

153 *See* GAO 1999, *supra* note 36, at 10.

154 10 U.S.C. § 1792 (1999).

155 *See* Zellman & Johansen, *supra* note 31, at 97.

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The RAND study found that these staff have had a positive effect in a range of areas. Because they do not have the responsibility for caring for children, like the caregivers, or for handling administrative issues, like the director, they are successful in part because they have time to focus on child development issues.[156] According to RAND, the results have included:

- *Improved curriculum design and staff training.* The specialists adopted training and curriculum materials and in some cases developed new materials. Most also implemented a process for monitoring curriculum delivery and staff training to ensure a developmental focus. Through its survey of CDC directors, the RAND study found that 86 percent of the CDCs made changes to their training sessions in response to the MCCA. The most frequently reported changes were a better structure (56 percent), better content (28 percent), and more hours of training (26 percent).[157]

- *Staff development.* Completion of the military's child care training program enabled individuals to apply for a CDA credential. The specialist often advised and encouraged caregivers to obtain this credential, and sometimes to achieve further education such as a BA.[158]

- *Facilitation of the accreditation process.* The specialists were able to dedicate their time to the accreditation process when CDCs prepared for the validation visit. Their background in child development was also seen as helpful in preparing for the CDC accreditation.[159]

d. Encouraging Parental Involvement

Congress set out through the MCCA to increase the involvement of parents in the CDCs, as a result of testimony by parents whose children had suffered abuse in military child care centers and who urged more parental involvement in centers and more accountability of centers to parents. The report of the House Armed Services Committee concluded that "involved parents make for better child development centers and the military would benefit greatly from increased parent participation in center activities and involvement."[160] The MCCA thus requires that each CDC establish a board composed of parents of children attending the center.[161] The board is required to meet periodically with center staff and the commander of the installation served by the center to discuss problems and concerns.[162]

While parent boards were widely implemented, a focus on other implementation issues led to an initial lack of guidelines or directives for them.[163] Nevertheless, parents are generally encouraged to participate in all aspects of the CDC programs.[164] In addition, all centers and FCC homes have an "open door" policy to encourage parents to visit their child's program, meet with child care staff and providers, and participate in their children's daily activities and special events.[165]

156 *See id.* at 99.

157 *See id.* at 99-103. According to Diane Trister Dodge, President of Teaching Strategies, Inc., who developed the training program for the military, the assistance of the training and curriculum specialists has been key to the successful implementation of the training program. Interview with Diane Trister Dodge, in Washington, D.C. (Mar. 23, 2000). *See also* Diane Trister Dodge, *Make the Most of Your Curriculum*, Children and Families, Spring 1999, at 29, 32-33.

158 See Zellman & Johansen, *supra* note 31, at 100.

159 *See id.* at 100-101.

160 H.R. Rep No. 101-121, at 308 (1989).

161 *See* 10 U.S.C. § 1795 (1999).

162 *See id.*

163 *See* Zellman & Johansen, *supra* note 31, at 127-28.

164 *See Partnerships*, *supra* note 117.

165 *Id.*

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The RAND study found that the parent boards have had varying levels of effect on the care provided at the CDCs.[166] It has been difficult to sustain parental involvement in the boards, though release time from work assignments has increased involvement for some parents.[167] Few boards have influenced CDC policy or operations.[168] On the other hand, many have become a resource relied upon by staff for repairs, support, and fund-raising.[169] The RAND researchers found that "most of the few parents" with whom they spoke were satisfied with their own level of involvement.[170] Many said their involvement was minimal because they trusted the CDC management.[171]

e. The Overall Impact of MCCA Implementation on Quality

Based on the results of its survey of the CDCs themselves, the RAND study found that the overall ratings of child care quality increased considerably after implementation of the MCCA.[172] Only 9 percent of respondents rated pre-MCCA care as "excellent," while over 60 percent rated care as excellent after MCCA implementation.[173] Seventeen percent of the respondents rated the quality of care prior to MCCA implementation as "not very good" or "not good at all" and 36 percent said it was "OK or fair." In contrast, none of the respondents described the care after MCCA implementation as "not very good" or "not good at all" and only 4 percent said it was "OK or fair."[174] These results were confirmed through interviews of military personnel conducted by RAND at a variety of military installations, where RAND investigators heard a consistent message that the quality of care had improved "substantially, sometimes dramatically, as a result of the MCCA."[175] In addition, in the instances in which RAND investigators visited the same CDC before the MCCA (during a previous RAND study) and after, they directly observed "tremendous improvements."[176] For example, they noticed improvements in resources and caregiver/child interactions.[177]

The quality of military child care also appears to be high when viewed from the perspective of expert research and opinion. Most experts in the field agree that child care quality is a product of appropriate staff/child interactions and curriculum, well-prepared providers, well-compensated providers, low staff/child ratios, a safe and healthy environment, and high levels of parental involvement.[178] Based on these measures, and as reflected in the strong record of NAEYC accreditation of military CDCs, the military is providing high-quality child care in its CDCs.

The RAND analysts concluded that although the MCCA focused mainly on center-based care, FCCs also improved. More provider training and more oversight contributed to improved quality of care and greater provider professionalism in FCC homes.[179]

166 *See* Zellman & Johansen, *supra* note 31, at 133.

167 *See id.* at 131.

168 *See id.* at 130.

169 *See id.* at 131-32.

170 *Id.* at 132.

171 *See id.*

172 *See id.* at 202.

173 *See id.* at 200, 203. Respondents were asked to rate quality on a five-point scale: excellent, very good, ok/fair, not very good or not good at all. *See id.*

174 *See id.* at 200, 202.

175 *Id.* at 206.

176 *Id.* at 207.

177 *See id.*

178 *See, e.g.*, Shelley Smith et al., National Conference of State Legislatures, Early Childhood Care and Education: An Investment that Works (1997); John M. Love et al., Mathematica Policy Research, Inc., Are They in Any Real Danger? What the Research Does—and Doesn't—Tell Us About Child Care Quality and Children's Well-Being 5-7 (1996).

179 *See* Zellman & Johansen, *supra* note 31, at 227, 236.

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The RAND report found that the youth programs that provide care for school-age children, with few exceptions, received little benefit from the MCCA. While RAND found some instances of improved training for before- and after-school program staff, and efforts to improve staff/child ratios in those programs, for the most part the MCCA's benefits did not extend to children over six years old.[180] Accordingly, one of RAND's principal recommendations was that youth programs be given more scrutiny and resources, and an expanded mission that included not only recreation, but also a focus on school-age children's development needs.[181] According to DoD, this has now occurred for the school-age programs serving children kindergarten through age twelve, and the Department's focus is currently on ways to improve youth programs serving children ages twelve to eighteen.[182]

2. MAKING CHILD CARE MORE AFFORDABLE

In addition to improving quality, a key goal of the MCCA was to make child care more affordable to military families, many of whom have relatively low incomes. Thus, financing for the child care system, as specified in the MCCA, is designed to ensure that programs have sufficient resources to maintain high-quality care while remaining affordable.

The MCCA establishes a spending floor for DoD child care, and directs DoD to allocate specific amounts to the Services according to their individual needs and requirements in order to "maximize child care resources."[183] It further requires that the annual federal appropriation for DoD operating expenses for CDCs at least equal the amount paid in parent fees in CDCs.[184] Thus, at a minimum, half the cost of operating the system is subsidized by Congressional appropriations.

The MCCA also directs DoD to establish a uniform schedule of parental fees for children in CDCs, based on family income.[185] Pursuant to this requirement, DoD designed a sliding scale payment schedule.[186] The table below shows the range of fees at different income levels for the school year beginning September 1, 1999.[187] These fees represent approximately 9 to 12 percent of income for families at the low end (up to $23,000)[188] and 8 percent or less for families at higher income levels ($70,000 and above).[189] The director of the military child development program has stated that an essential principle of the program is that every family receive some subsidy, to ensure that child care is seen as a universal program and not one just for low-income families.[190]

180 *See id.* at 230-33.

181 *See id.* at 238-39.

182 *See* U.S. Department of Defense, *Information Paper: Department of Defense (DoD) Strategic Youth Action Plan* (April 2000); U.S. Department of Defense, *Information Paper: Status of Military Youth* (March 2000); U.S. Department of Defense, *Information Paper: Department of Defense (DoD) Military Youth Programs* (March 2000); U.S. Department of Defense, *Information Paper: Department of Defense (DoD) Youth Partnership Initiative* (March 2000).

183 H.R. Conf. Rep. No. 101-331, at 663 (1989).

184 *See* 10 U.S.C. § 1791 (1999).

185 *See* 10 U.S.C. § 1793 (1999).

186 DoD specifies that total family income includes the military's minimum basic allowance for housing and the basic allowance for subsistence. This allows fees to be standardized for military personnel in different situations (e.g., those receiving a housing subsidy vs. those living on a base) and to be based on income comparable to civilian income. *See* Memorandum from the Acting Assistant Secretary of Defense, DoD Child Care Fee Ranges for 1999-2000 (June 25, 1999) (on file with the National Women's Law Center).

187 DoD allows commanders to set the fees at their installations within these ranges. There is also an optional "high cost range," with slightly higher weekly fee ranges that may be used in areas where it is necessary to pay higher provider wages in order to compete in the local labor market. Commanders have the authority to offer a 20 percent fee discount for each additional child from the same family and to grant hardship waivers for families facing difficult financial circumstances. *See id.*

188 Although the scale reflects incomes from $0 to $23,000, the lowest military pay (including housing and basic subsistence allowances) for an individual with dependents is approximately $20,500. See U.S. Department of Defense, *FY2000 RMC Tables*, at A2-A3 (2000) [hereinafter *RMC Tables*].

189 *See id.*

190 *See* Smith, *supra* note 20.

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Parental Child Care Fees in Military Child Development Centers

Total Family Income	Range of Weekly Fees Per Child 1999-2000
$0-$23,000[191]	$39-$52
$23,001-$34,000	$49-$63
$34,001-$44,000	$60-$75
$44,001-$55,000	$73-$85
$55,001-$69,999	$87-$99
$70,000+	$101-$112

Source: Memorandum from the Acting Assistant Secretary of Defense, DoD Child Care Fee Ranges for 1999-2000 (June 25, 1999) (on file with the National Women's Law Center).

Family child care providers, as independent contractors, set their own fees.[192] When an FCC provider receives a direct cash subsidy from DoD, however, the installation commander sets the fees that may be charged to parents by that provider.[193] As described above, the MCCA provides that DoD may use appropriated funds to help subsidize FCCs so that FCC services may be provided at a cost to parents comparable to the cost of CDCs; DoD, in turn, leaves to commander discretion the provision of such subsidies. The RAND analysts noted that since 1989, fees charged by FCC providers had increased, but CDC fees had decreased, especially for lower-income families, and that this had increased the demand for center care.[194] Accordingly, they urged far more widespread use of direct cash subsidies for FCC care, noting that this would make FCC care more affordable and therefore more attractive to parents, and possibly reduce CDC waiting lists as a result.[195] It would also, they noted, help to create more affordable slots for infants; these slots are in shortest supply and are often needed by the lowest-ranked personnel (who have the youngest children).[196] According to DoD, the current use of subsidies for FCC providers in the Army, Navy, and Marine Corps has reduced the cost of care for families with children in FCC homes.[197]

When school-age care is provided on a military base in a school, CDC, or other facility, the fee is subsidized based on family income according to the general rule for CDC care.[198] When school-age care is provided in a family child care home, it is governed by the general rule for FCC care—that is, each provider sets the fee unless the provider receives a direct cash subsidy.[199]

Compared with the cost to parents of civilian child care, the military system appears to be successful in providing affordable care, at least in CDCs. The RAND analysts found that the average weekly fee paid by military families in 1993 was substantially—almost 25 percent—lower than the average weekly fee paid by civilian families with children in comparable center-based care, even through civilian families typically used care only

191 *See supra* note 188.

192 *See Family Child Care, supra* note 59.

193 *See id.*

194 *See* Zellman & Johansen, *supra* note 31, at 136.

195 *See id.* at 241-42.

196 *See id.*

197 *See* Interview with Linda Smith, *supra* note 85.

198 *See id.* Fees for school-age programs are based on the same five income categories as CDC fees and the number of service hours per week; they generally range from $4-10 (for five hours or less) to $37-105 (for 50 hours). *See* Memorandum from the Acting Assistant Secretary of Defense, DoD School-Age Care Fee Ranges for 1999-2000 (July 19, 1999) (on file with the National Women's Law Center).

199 *See id.*

thirty-eight hours per week as opposed to fifty hours for military families and military centers generally included younger children (including infants) than civilian centers.[200]

Using more current numbers, for 1998-99, the average annual cost to military families for full-time, center-based care for one child (including infants) was $70 a week or $3,640 annually.[201] In contrast, a 1998 survey of average annual costs to parents for civilian full-time, center-based child care for a four-year-old child in selected cities across the country ranged from a low of $3,342 in Birmingham, Alabama, to a high of $7,904 in Boston, Massachusetts.[202] Similarly, a 1995 Census Bureau report found that the average cost to parents per preschooler for center-based care was $65.42 a week, equivalent to $3,690 per year in 1998 dollars, $50 dollars more than the average annual cost to parents for such care in the military.[203] The lower fees paid by military families are a result of the subsidies the military provides, not lower costs to the military of providing child care; indeed, the GAO recently reported that the hourly per-child cost to the military of providing care in CDCs in 1997 was slightly (about 7 percent) higher than the cost to civilian centers of providing care of comparable quality.[204]

3. EXPANDING CHILD CARE AVAILABILITY

The third way in which the military improved its child care system was by expanding the availability of care to families who need it. In contrast to the MCCA's detailed provisions regarding the quality and affordability of care, the statute does not include specific requirements for expanding child care capacity. However, the MCCA did require DoD to outline a plan for addressing the unmet need for care,[205] and DoD did so in 1992.[206] The first step was to develop a formula for measuring the need for military child care, both at the department-wide level and for individual installations, taking into account a range of demographic factors (such as the number of children of military families in different age groups, and the percentage of children of single parents and of dual-working parents).[207] Then DoD developed a method for measuring unmet demand, and established an aggressive plan to meet

200 *See* Zellman & Johansen, *supra* note 31, at 70-71. Approximately 48 percent of the children currently in military centers are infants and toddlers, compared to 15 percent in civilian centers. *See* Smith, *supra* note 20. The cost to parents of infant care in a military CDC is not higher than the cost of care for an older child, *see id.*; in contrast, infant care is generally the most expensive type of civilian child care to parents. For instance, a 1998 survey of child care costs found that the average cost of center care for a twelve-month-old was over $5,500 per year in half the states, including 11 urban areas where costs averaged more than $7,000 per year. *See* Karen Schulman & Gina Adams, Children's Defense Fund, Issue Brief: The High Cost of Child Care Puts Quality Care Out of Reach for Many Families, at A-5 (1998). In every state, the annual cost of infant care at a center in an urban area was more than the cost of public college tuition. *See id.* at A-2.

The RAND study, relying on data from the 1990 National Child Care Survey, also concluded that while military families, on average, paid a higher percentage of their total income for child care than civilian families, the lowest-income military families (with incomes between $11,000 and $27,000) spent a slightly lower proportion of cash income on child care than those in the civilian sector (13.2 percent vs. 14.4 percent). *See* Zellman & Johansen, *supra* note 31, at 74. According to a 1995 Census Bureau report, the percentage of income spent on child care for preschoolers is even higher for civilian families below the poverty level: these families spend an average of 17.73 percent of their income on child care payments. *See* Lynne M. Caspar, Census Bureau, *Current Population Reports: What Does It Cost to Mind Our Preschoolers?*, Table 3 (September 1995).

201 *See* Smith, *supra* note 20.

202 *See* Schulman & Adams, *supra* note 200, at A-6.

203 *See* Caspar, *supra* note 200, at Table 2.

204 *See* GAO 1999, *supra* note 36, at 19. The GAO studied only Air Force CDCs, because the Air Force was the only Service whose centers had all demonstrated high quality by meeting the NAEYC accreditation standards. The GAO found that the hourly cost of providing care was about 20 percent higher in Air Force centers than in civilian centers of comparable quality because the Air Force's labor costs were higher, but once an adjustment was made for the younger ages of the children in the Air Force centers, the differential decreased to about 7 percent. *See id.* DoD estimates that the average direct operating cost of providing full-time care in a military CDC is currently $7,200 per child. *See* Smith, *supra* note 20. Low-income families ($20,000 - $23,000), pay, on average, about a third of this cost in fees; high-income families (over $55,000) pay about two-thirds. *See id.*

205 *See* Department of Defense Authorization Act of 1989, Pub. L. No. 101-189, Title XV, § 1507, 103 Stat. 1352, 1595.

206 *See* Office of the Secretary of Defense, U.S. Department of Defense, *A Report to Congress: The Potential Demand for Child Care within the Department of Defense and a Plan to Expand Availability* (1992) [hereinafter *A Report to Congress*].

207 *See* U.S. Department of Defense, *Military Child Development Program: The Need for Child Care* (visited March 16, 2000) <http://dticaw.dtic.mil/milchild/need.html> [hereinafter *The Need for Child Care*].

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the demand, which it included in its 1992 report to Congress.[208] The Department has generally followed this plan for increasing child care capacity, including taking the following steps:[209]

- *Continuing center construction and additions.* In 1992, the report to Congress stated that the Services would continue to aggressively support construction of child care facilities with appropriated funds.[210] In the years that have followed, where possible, the military has constructed new centers or expanded existing ones.[211] Congress has traditionally been generous to the military in funding these efforts.[212]

- *Increasing slots at existing facilities.* At some installations, because of space and facility limitations, expansions for center-based care could be achieved only by reorganizing the type of care provided at installation facilities.[213] The 1992 report to Congress proposed to achieve this reorganization by moving hourly and drop-in care to other facilities such as FCCs, youth facilities, chapels, and community recreation centers.[214] Similarly, when appropriate, the plan called for programs for school-age care to be moved to facilities at local school districts, including DoD Dependents Schools and local school districts in communities with large military populations.[215] The Defense Department has since implemented this plan.[216]

- *Increasing the capacity of the FCCs.* The military has sought to increase capacity through expanding its family child care program.[217] The 1992 plan recommended better matching of families with FCCs through the resource and referral agencies, improvement in the quality and oversight of FCC programs, and the use of appropriated funds to subsidize these providers;[218] the steps recommended in this plan are still being implemented.[219]

- *Increasing the role of resource and referral agencies.* The 1992 plan called for the continued expansion of child care resource and referral agencies to help military families locate licensed, safe, and affordable off-base care.[220] These agencies are available at most bases and provide information to all parents, free of charge, on the child care options available at their installations and, when needed, in the broader local community.[221] Resource and referral agencies manage the waiting lists for care on an installation and find alternatives for families if their first choice of a provider is not available.[222] Referrals are made to non-military, licensed providers in the community when installation care is not available.[223] The Defense Department has followed this plan to improve access to care.[224]

208 *See* id.; *A Report to Congress*, *supra* note 206, at 17-21.
209 *See The Need for Child Care*, *supra* note 207; Interview with Linda Smith, *supra* note 85.
210 *See A Report to Congress*, *supra* note 206, at 20.
211 *See* Interview with Linda Smith, *supra* note 85.
212 *See* id.
213 *See* id.
214 *See A Report to Congress*, *supra* note 206, at 18.
215 *See* id. at 18-19.
216 *See The Need for Child Care*, *supra* note 207; Interview with Linda Smith, *supra* note 85.
217 *See The Need for Child Care*, *supra* note 207; Interview with Linda Smith, *supra* note 85.
218 *See A Report to Congress*, *supra* note 206, at 19-20.
219 *See The Need for Child Care*, *supra* note 207; Interview with Linda Smith, *supra* note 85.
220 *See A Report to Congress*, *supra* note 206, at 20.
221 *See* Interview with Linda Smith, *supra* note 85; U.S. Department of Defense, *Military Child Development Program: Child Care System* (visited April 2, 2000) <http://dticaw.dtic.mil/milchild/system.html>.
222 *See* Interview with Linda Smith, *supra* note 85.
223 *See* id.; *The Need for Child Care*, *supra* note 207.
224 *See The Need for Child Care*, *supra* note 207; Interview with Linda Smith, *supra* note 85.

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- *Using off-base care.* The 1992 report recommended seeking alternative sources of child care as installation options were exhausted, including the use of contracts with off-installation centers to guarantee space for DoD children.[225] For installations where quality, affordable care is available in the community, the military has encouraged use of off-base, licensed care.[226]

As a result of these efforts, the military has been successful in dramatically increasing its child care capacity. Between fiscal years 1985 and 1998, the Services built about 208 new centers.[227] The system now provides over 173,000 slots, serving over 200,000 children on a daily basis worldwide[228]—a figure close to three times the number of slots in 1989, as estimated by the General Accounting Office.[229] Currently, there are over 800 CDCs providing over 62,000 child care slots, and 9,900 FCCs providing approximately 60,000 slots.[230] The newer programs for school-age children provide roughly 38,000 slots.[231] While capacity has increased, the demand for child care still exceeds supply. The Defense Department estimates that an additional 126,000 slots for children in military families are needed.[232] Some installations continue to have waiting lists for care, particularly for infant care. The military estimates that it is currently meeting about 58 percent of its estimated child care need,[233] and has a goal of reaching 80 percent by 2005.[234] To achieve this goal, efforts will continue to focus on the expansion of slots on military installations[235] and in the communities surrounding military installations.[236] The latter have become more important as CDCs, FCCs, and youth centers on military installations reach full capacity.

Because DoD is committed to ensuring the same high quality of care off-base as on, it is finding that partnerships with community-based providers may require an infusion of DoD funds. Accordingly, the DoD authorization for Fiscal Year 2000 permits DoD to provide financial assistance to civilians who provide child care services to members of the Armed Services, when such assistance supplements or expands child care services or youth program services for military installations and ensures that the provider can and will comply with applicable DoD regulations, policies, and standards.[237] To be eligible, the civilian provider must be licensed and must have previously provided child care services for members of the Armed Services or federal employees.[238] DoD may also authorize the participation of civilian children in military child care programs in order to support the integration of children of military families into civilian communities, make more efficient use of DoD facilities and

225 *See A Report to Congress, supra* note 206, at 20.

226 *See The Need for Child Care, supra* note 207; Interview with Linda Smith, *supra* note 85. In recent years, as the military is approaching full capacity on installations, efforts to expand off-base care, including through partial subsidy of such care, have increased. *See* discussion *infra* accompanying notes 237-39.

227 *See* GAO 1999, *supra* note 36, at 14. Based on an earlier survey of CDCs in 1993, the RAND analysts found that since the enactment of the MCCA, 40 percent of the directors reported more full-time CDC spaces, 40 percent reported no change in the number of spaces, and 20 percent reported fewer full-time spaces. The reduction in spaces in some CDCs was often due to the enforcement of lower caregiver/child ratios, which led to a decrease in the number of children served. Approximately one-third of the CDCs in the RAND survey reported an increase in the number of full-time slots provided by FCCs. *See* Zellman & Johansen, *supra* note 31, at 216, 222.

228 *See Child Development System Size, supra* note 56. Because of part-time care, the number of children served is larger than the number of slots. *See* Interview with Linda Smith, *supra* note 58.

229 *See* GAO 1989, *supra* note 12, at 3.

230 *See* Military Family Resource Center, *supra* note 14, at 37.

231 *See id.* These figures do not add up to exactly 173,000, because they do not include children receiving very short-term care (*e.g.*, for two weeks) that is sometimes provided when parents participate in special training courses. They also exclude families receiving assistance from resource and referral agencies, including families attempting to find child care outside the installation. *See* Interview with Linda Smith, *supra* note 85.

232 *See The Need for Child Care, supra* note 207.

233 *See* Office of Family Policy, U.S. Department of Defense, *Need for Child Care Spaces by Service* (March 2000).

234 *See* GAO 1999, *supra* note 36, at 14.

235 As discussed above, the military is currently making more use of direct cash subsidies to FCC providers to increase the overall supply of FCC homes.

236 *See The Need for Child Care, supra* note 207.

237 *See* 10 U.S.C. § 1798 (1999).

238 *See id.*

resources, and form partnerships with schools and other youth services organizations serving children of members of the Armed Services.[239] These provisions will allow DoD to subsidize FCC homes serving military families off-base and help child care centers and school-age programs serving military families off-base improve the quality of their care.

4. ADDING RESOURCES FOR CHILD CARE

Achieving the improvements described above in the quality, affordability, and availability of military child care has required an increase in appropriated funds. In FY 1989, prior to enactment of the MCCA, $89.9 million was appropriated for military CDCs.[240] In the MCCA, Congress authorized an increase to $102 million in appropriated funds for FY 1990 for military CDCs along with $26 million for other child care and child-related services.[241] At that time, because additional funds were not appropriated, DoD had to shift funds from other activities to child care, and this aspect of MCCA implementation was initially complex and difficult.[242] But by FY 2000, about $352 million in appropriated funds were obligated for DoD's child development program as a whole, of which DoD allocated 73 percent to CDCs ($257 million), 12 percent to FCCs ($43 million), 11 percent to school-age care ($38 million), and 4 percent ($14 million) for resource and referral.[243] These funding increases clearly demonstrate the increased priority that has been given to military child care in the space of just over ten years.

239 *See* 10 U.S.C. § 1799 (1999).

240 *See* Burrelli, *supra* note 10, at 10.

241 *See* Department of Defense Authorization Act of 1989, Pub. L. No. 101-189, Title XV, § 1502, 103 Stat. 1352, 1590.

242 *See* Zellman & Johansen, *supra* note 31, at 33-34.

243 *See* Interview with Linda Smith, *supra* note 57. DoD funds from other sources continue to help finance military child care. For example, indirect costs such as rent and utilities are borne by the installation but not charged as child care costs. *See id.*

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IV. LESSONS LEARNED

A. CIVILIAN CHILD CARE TODAY

The problems that characterized military child care before the MCCA find many direct parallels in the problems affecting child care across the United States today in all three areas: availability, quality, and affordability.

Availability As unprecedented numbers of women with children have entered the paid labor force, the demand for child care has intensified. Today, seven out of ten American women with children under the age of eighteen—and over three out of four women with school-age children—work in the paid labor force, representing a major societal change since the 1940s when fewer than one in five women with children worked outside the home.[244] Yet despite the increased need for child care services for these families, some communities have little or no licensed care, particularly for infants, school-age children, special-needs children, and children needing non-standard hours care. For instance, a 1997 GAO study found that in Baltimore County, Maryland, the number of child care slots was sufficient to meet only 37 percent of the demand for infant care, leaving more than 3,300 infants without care.[245] In Chicago that year, only 16 percent of the demand for infant care could be met, leaving more than 17,000 infants unserved.[246] In Dallas, only one in five children ages five to eleven with parents in the workforce had access to slots in after-school programs in 1996, according to estimates by the Dallas Commission on Children and Youth.[247] The 1997 GAO report found that at the sites reviewed, only 12 to 35 percent of providers offered care during non-standard hours, and most of these providers were family child care homes, with lower capacity than that provided by centers,[248] while a 1995 GAO study found that six out of seven states surveyed reported a shortage in special-needs child care.[249]

Quality Even when child care is available, its quality is often poor or mediocre. A National Institute of Child Health and Human Development (NICHD) study, involving 1,103 children between 1991 and 1999, found that only 39 percent of child care is rated good or excellent,

244 *See* U.S. Bureau of Labor Statistics, Current Population Survey (1998); U.S. House of Representatives Comm. on Ways and Means, 1996 Green Book, Table 10-1 (1996).

245 *See* U.S. General Accounting Office, Report to the Ranking Minority Member, Welfare Reform: Implication of Increased Work Participation for Child Care 9-10 (1997) [hereinafter GAO 1997].

246 *See id.*

247 *See* Julia Easley et al., Beyond ABC: Growing Up in Dallas County 45 (1998).

248 *See* GAO 1997, *supra* note 245, at 15.

249 *See* U.S. General Accounting Office, Report to Congress, Welfare to Work: Child Care Assistance Limited; Welfare Reform May Expand Needs 8 (1995).

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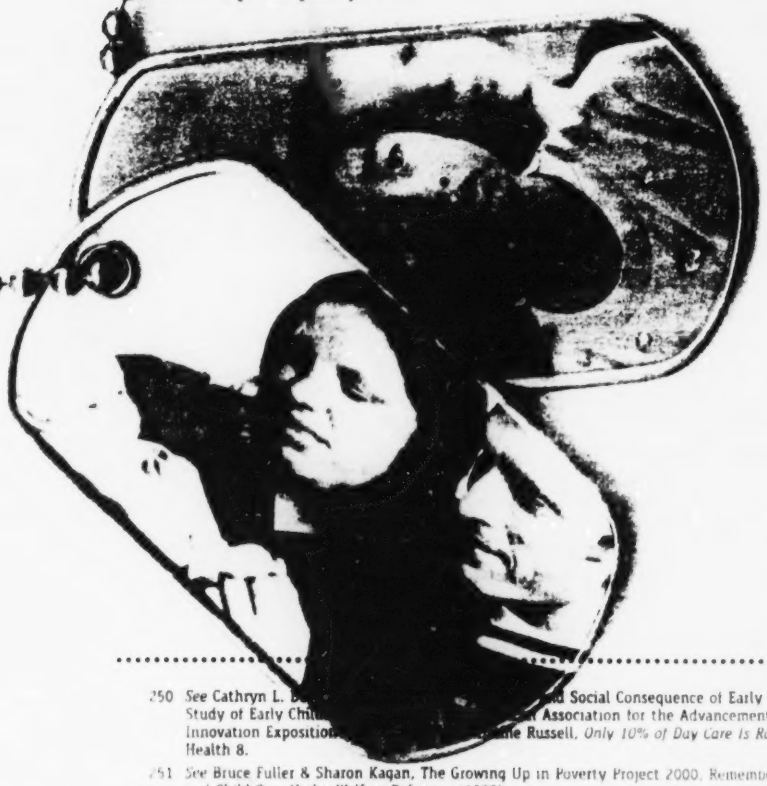
while 53 percent is rated fair and 8 percent is rated poor.[250] Recent research reveals that the children of mothers moving from welfare to work are at particular risk of being moved into low-quality child care settings.[251] Many young children are being cared for in settings in which the materials required for physical and intellectual growth are missing; warm, supportive relations with adults are lacking; and in some cases, basic sanitary conditions are not met and safety problems are endangering the children.[252] Indeed, one study of four states found fully 40 percent of the rooms serving infants in child care centers to be of such poor quality as to jeopardize children's health, safety, or development.[253] Studies of family child care have produced equally troubling results.[254]

The quality of child care in the United States is often low in part because child care workers are poorly compensated and therefore do not stay long in the field.[255] The U.S. Department of Labor reports that, in 1998, the average wage for a child care worker in a center was $7.13 per hour or $14,820 annually, less than that of bus drivers, barbers, data entry keyers, janitors, or even parking attendants.[256] Family child care providers earned even less, with a median wage of $4.69 per hour in 1997.[257] As a result, the turnover rate for child care workers in centers averaged 31 percent in 1998.[258] Low wages and high turnover translate into poor-quality care.[259]



250 *See* Cathryn L. B... ...d Social Consequence of Early Experience: Perspectives from the NICHD Study of Early Chil... ...t Association for the Advancement of Science Annual Meeting and Science Innovation Exposition... ...ne Russell, *Only 10% of Day Care Is Rated Excellent*, Wash. Post, Feb. 23, 1999, Health 8.

251 *See* Bruce Fuller & Sharon Kagan, The Growing Up in Poverty Project 2000, Remember the Children: Mothers Balance Work and Child Care Under Welfare Reform 4 (2000).

252 *See* Suzanne Helburn et al., Cost, Quality, and Child Outcomes in Child Care Centers (1995).

253 *See id.*

254 *See* Ellen Galinsky et al., Families and Work Institute, The Study of Children in Family Child Care and Relative Care: Highlights of Findings 81 (1994).

255 *See* Center for the Child Care Workforce, Worthy Work, Unlivable Wages 18-19 (1998) [hereinafter Worthy Work, Unlivable Wages].

256 *See* Bureau of Labor Statistics, U.S. Department of Labor, *National employment and wage data from the Occupational Employment Statistics survey by occupation, 1998* (last modified Dec. 22, 1999) <http://stats.bls.gov/news.release/ocwage.t01.htm>. This is the average wage for child care workers in centers, schools, businesses, and institutions. It excludes preschool teachers and teacher aides. *See* Bureau of Labor Statistics, U.S. Department of Labor, *1998 National Employment and Wage Estimates: Child Care Workers* (last modified Mar. 10, 2000) <http://stats.bls.gov/oes/national/oesb8038.htm>.

257 *See* Center for the Child Care Workforce, *Current Data on Child Care Salaries and Benefits in the United States, 1999* 3 (1999).

258 *See* Worthy Work, Unlivable Wages, *supra* note 255, at 19.

259 *See id.* at 22.

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Affordability Even when high-quality care is available, parents often cannot afford to pay for it. A 1998 survey of child care costs in 47 cities found that the average annual cost of care for a four-year-old in a child care center ranged from $3,342 in Birmingham, Alabama, to $7,904 in Boston, Massachusetts.[260] Average costs for infant care were even higher, from $3,633 in Knoxville, Tennessee, to $12,324 in Boston.[261] Sufficient public funds have not been allocated to help parents meet these costs.[262] Because of inadequate state and federal funding and a lack of information about eligibility, only one in ten children in low- and moderate-income families that were eligible for Child Care and Development Block Grant (CCDBG) subsidies actually received help in fiscal year 1998.[263] Even when families receive some governmental assistance, fees or co-payments can remain a staggering financial burden. In Oregon, for example, a family of three with an annual income of $20,820 receiving a child care subsidy would have to contribute $365 a month for child care—more than 20 percent of the family's income.[264]

As shown by this very brief overview of the state of child care in the U.S. today, policies and initiatives to improve the availability of high-quality, affordable child care across the country are sorely needed.

B. LESSONS FROM THE MILITARY FOR IMPROVING CIVILIAN CHILD CARE

How can policy makers, child care administrators, advocates, providers, parents, and others who seek to address these problems in civilian child care benefit from the military's experience in overhauling its system? What can be learned from the military's ability to transform its child care system, in fairly short order, from one labeled "a disaster"[265] to one held out as a model for the nation?[266]

Six key lessons are set forth below. It is important to note, in considering them, that Congress and DoD were successful in reforming the military's child care system in part because they prescribed in some detail, either in the MCCA or in regulations issued by DoD, how the problems confronting military child care were to be addressed—specifying, for example, the minimum number of unannounced inspections per year, the precise components of required staff training, and the schedule of parent fees based on income. In translating the military's approaches to civilian child care, then, policy makers should not be reluctant to impose detailed requirements if they wish to ensure success.

Lesson # 1:
Do Not Be Daunted by the Task: It Is Possible to Take a Woefully Inadequate Child Care System and Dramatically Improve It.

The military's success in overhauling its child care system demonstrates that it is possible to transform a severely inadequate child care system into one that provides quality care at an affordable cost for a steadily increasing number of families who need it. In some respects, unique aspects of the military enabled it to effect change in a manner that is not easily replicated elsewhere. The military is a quintessentially hierarchical, rule-based institution that functions on the basis of orders given from above and complied with down the chain of

260 *See* Schulman & Adams, *supra* note 200, at A-6.

261 *See id.*

262 *See* Administration for Children and Families, U.S. Department of Health and Human Resources, Access to Child Care for Low-Income Working Families 2 (1999).

263 *See id.*

264 *See* Helen Blank & Nicole Oxendine Poersch, Children's Defense Fund, State Developments in Child Care and Early Education 1999 26-27 (2000).

265 Cottle, *supra* note 1.

266 *See, e.g.*, White House Press Release, *supra* note 6.

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command; it also is a unified system, in which all of the component parts are linked (*e.g.*, all child care center administrators and staff have a common employer, which also supervises all FCC providers). Thus, for example, DoD headquarters can issue and implement standardized requirements for providers in ways not as readily available to state child care administrators who oversee a range of private child care providers, many of whom may not receive public funding. But it is important not to overstate this aspect of military life. Each of the Services has its own unique features, which Congress or DoD must consider in developing any requirements intended to be applied universally. Moreover, the discretion of both the individual Services and commanders in the field to determine what is best for their Service or command—especially on issues whose resolution may vary considerably, depending on the circumstances—is an important aspect of the way the military traditionally has functioned. This reality is not so different from the constraints faced by a state seeking to develop an effective child care system that includes elements of state prescription and local discretion.

Another feature of the military might be expected to translate into resistance to making child care—historically not an official military program at all—a high priority. The military is a notably conservative institution that is often averse to change (especially when imposed by Congress).[267] Indeed, the RAND analysts found that there was initial reluctance to follow the mandates of the MCCA in some quarters.[268] And yet, in just a decade, this reluctance was overcome and the system overhauled. *The lesson: if even a tradition-bound institution like the military can turn its child care system around, similar progress should be achievable in all kinds of civilian settings, all across the country.*

Lesson # 2:
Recognize and Acknowledge the Seriousness of the Child Care Problem and the Consequences of Inaction.

In the case of the military, policy makers in Congress and in DoD acted to address military child care after extensive Congressional hearings and GAO reports exposed the poor state of military child care and documented the harsh consequences that had resulted. These revelations prompted policy makers to find the necessary resources—hundreds of millions of additional dollars—and allocate them to improving the military child care system.

On the civilian side, families know all too well the difficulties they face in finding and paying for appropriate care for their children—just as military personnel knew of the problem well before Congress and DoD addressed it. Advocates, too, understand the problem and have been pressing policy makers to make a greater commitment to resolving it. But, with some exceptions, policy makers with the power to do something about civilian child care, at the federal and state levels, have not yet made the issue a top priority. Thus, greater attention must be focused on the shortage of high quality, affordable child care for civilian families across the United States, and its adverse consequences.

Emphasize workforce impact

Two sets of concerns were particularly powerful motivations for improving military child care, and each of them should be equally compelling in the civilian child care context. One is that *when the availability of high-quality, affordable child care is inadequate to meet the needs of a changing workforce, workforce performance suffers.* The work of reforming military child care began in earnest with a recognition that the child care system was not adequately serving the needs of the men and women comprising the all-volunteer Armed Services, and that as a consequence, military readiness was in jeopardy of being compromised. In the hearings leading to passage of the MCCA, it was repeatedly noted that the demographics

267 *See* Zellman & Johansen, *supra* note 31, at 17.
268 *See id.* at 162.

of the military workforce had changed (*i.e.*, more Service members had children and no spouse at home to care for them), the child care system had not kept pace with these changes, and the result was lowered productivity of military personnel due to absenteeism and tardiness, and retention problems due to dissatisfaction with military life. Access to child care was affecting how military families were able to perform their jobs, and had become "an important readiness and retention issue."[269] An understanding of that fact helped prompt improvements in the child care system.

In the civilian world, too, significant demographic changes have occurred (there are more women with children in the workforce), and studies suggest that, as a result, the absence of suitable and reliable child care is having a negative impact on worker recruitment, retention, and performance.[270] Some employers have acted to provide child care assistance to their employees precisely because of this workforce issue.[271] But it is essential that policy makers recognize the connection between access to good child care and maximizing workforce performance, just as they did in the military context.

Emphasize children's welfare

The second set of concerns that prompted changes in military child care related to *the welfare of the children*. The hearings and debates on military child care abounded with reports of unsafe, dilapidated facilities; incidents of child abuse; and poor wages, training, and working conditions for child care staff, which resulted in astronomical turnover rates. All of these problems, which had an obvious and direct impact on the quality of care provided to children, were clearly troubling to the military and to members of Congress.

Similar concerns should prompt action to improve civilian child care. While it is important not to exaggerate the extent to which some of the problems in military child care before the MCCA are prevalent in civilian child care today—such as child abuse or dangerous facilities—it is the case that the quality of much of the child care across the United States today is rated as no better than mediocre, and that the lack of good quality child care and constructive programs for school-age youth can have significant and long-lasting effects on children's healthy development and learning. Advocates and the media have helped to increase public awareness of this reality, but policy makers need to understand and acknowledge it as a first step toward taking action to address it.

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269 H.R. Rep. No. 101-121, at 307 (1989).

270 See U.S. Department of the Treasury, Investing in Child Care: Challenges Facing Working Parents and the Private Sector Response 5 & (1998).

271 A 1998 survey of a representative sample of 1,109 employers conducted by the Families and Work Institute found that the most common reasons given for investing in work/family policies, including child care assistance, were (1) to retain employees at all levels of the workforce; (2) to help employees balance work and family life; and (3) to improve employee morale. See id. at 10; *see also* Kirsten Downey Grimsley, *A Little Baby Powder on the Bottom Line: Corporate Child Care Can Help Boost Profits*, Wash. Post, July 17, 1998.

Lesson # 3:
Improve Quality by Establishing and Enforcing Comprehensive Standards, Assisting Providers in Becoming Accredited, and Enhancing Provider Compensation and Training.

a. Develop Comprehensive, Uniform Standards, and Ensure That They Are Met Through a System of Unannounced Inspections and Sanctions for Violations.

Establishing and enforcing comprehensive standards is critical to improving child care quality. The military has shown that establishing comprehensive standards and rigorously enforcing them—including through repeated, unannounced inspections and highly visible sanctions for failing inspections—raise the quality of care. In civilian child care today, programs must meet state and/or local licensing and quality standards, but these standards vary considerably from state to state; significantly, some programs are exempt from any protections. For example, almost all states exempt some types of out-of-home providers (in addition to relatives) from regulation.[272] Moreover, while state child care requirements generally cover supervision and curriculum to some extent, their primary focus is basic health and safety requirements.[273] Thus, there is much room for improvement in state and local standards.

Strengthen standards

Some states have taken steps to improve the quality of care by strengthening their standards. In 1998, Tennessee improved its staff/child ratios for infants and toddlers,[274] and Florida enacted legislation to create and implement standards for school-age care.[275] In 1997, North Carolina strengthened its licensing standards, requiring among other things, that all providers obtain and display a license including ratings reflecting program standards, staff education level, and program history, to provide parents with more program information.[276] But *more states could achieve the military's success in significantly increasing the quality of care by comparing their standards to those established by outside experts,*[277] *strengthening them when appropriate, and applying them to a wide range of care.*

States should also do more to improve their monitoring and enforcement efforts to ensure compliance with applicable standards. No state, for example, requires four unannounced inspection visits a year, as the military does in facilities all over the world. Some states require visits to centers and family child care homes less than once a year and very few require visits more than twice a year; fourteen states require family child care visits less than once every *five* years;[278] and not all states require inspection visits to be unannounced.[279]

Strengthen enforcement

In addition, the evidence suggests that enforcement activities required by state regulations are not always carried out. Most state inspectors have caseloads exceeding the recommended level; in about one-third of states caseloads are more than twice the recommended

272 For instance, in 1999, one out of every five states exempted family child care homes serving five or fewer children from all health and safety protections and from any screening of the provider's background. *See* Kay Hollestelle, Children's Foundation, The 1999 Family Child Care Licensing Study (1999); *see generally* U.S. General Accounting Office, Report to Congressional Requesters, Child Care: State Efforts to Enforce Health and Safety Requirements 20-22 (2000) [hereinafter GAO 2000].

273 *See* GAO 2000, *supra* note 272, at 5. Under federal law, states need only certify that they have licensing requirements applicable to child care services provided in the state and provide a description of these requirements and how they are enforced to receive CCDBG funding. *See* 42 U.S.C. § 9858c(c)(2)(E) (1999). No specific state licensing requirements are mandated by CCDBG, so long as the state standards cover the following areas: prevention and control of infectious diseases, building and physical premise safety, and minimum health and safety training appropriate to the provider setting. *See* 42 U.S.C. § 9858c(c)(2)(F) (1999).

274 *See* Helen Blank & Nicole Oxendine Poersch, Children's Defense Fund, State Child Care and Early Education Developments: Highlights and Updates for 1998 45 (1999) [hereinafter Blank & Poersch 1998].

275 *See* Blank & Poersch, *supra* note 264, at 35.

276 *See* Helen Blank & Gina Adams, Children's Defense Fund, State Developments in Child Care and Early Education: 1997, at 59 (1997).

277 *See, e.g.*, Maternal and Child Health Bureau, U.S. Department of Health and Human Services, Stepping Stones to Using Caring [sic] for Our Children: National Health and Safety Performance Standards for Out-of-Home Child Care (1997).

278 *See* GAO 2000, *supra* note 272, at 13-16, App. I.

279 *See id.* at 14.

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level.[280] Fewer than half of the states have pre-service training requirements for licensing staff.[281] An audit of five states by the Office of the Inspector General of the U.S. Department of Health and Human Services in 1994 found numerous instances where child care facilities did not comply with the health and safety standards on the books. The deficiencies that were found included fire code violations, toxic chemicals, playground hazards, unsanitary conditions, other facility hazards, and inadequate record-keeping on employees and children.[282] The Inspector General concluded that among the reasons for these lapses were that the states routinely announced site inspections to child care facilities, that they seldom imposed sanctions on facilities for violating safety standards (even where there were recurring violations), and that they had too few inspectors to effectively monitor facilities.[283]

The states' record in this area has improved somewhat in the last few years,[284] but *the military's approach sets out a model the states should emulate: establish a rigorous inspection program, ensure that all mandated inspections are carried out on an unannounced basis, and impose meaningful, well-publicized sanctions for non-compliance.*

Strengthen parental involvement

Other techniques used by the military to ensure compliance are important to ensuring quality as well. The military has attempted to help ensure the safety and quality of child care services by giving parents opportunities to participate in the care their children receive (through parent boards) and to observe it (through the military's "open door" policy for child care providers), as well as to report any safety violations or suspected child abuse (through the military's national hotline). Research has shown that parent and family engagement in child care programs is important in improving the quality of care and outcomes for children.[285] Head Start has long had parent boards[286] and some states recently have taken steps to assist parents in becoming better informed about the care their children receive (for instance, in 1999, Illinois began operating a parent information hotline that allows parents to access information regarding provider licensing violations).[287] *All states should encourage, as the military has done, a high level of parent involvement in their children's care.*

b. Assist Providers in Meeting Additional Voluntary Standards, Such as Those Necessary for Outside Accreditation.

The way in which the military not only requires that providers meet a set of basic certification requirements but also assists them in meeting higher standards to become accredited—and the success it has had with this system—provides a useful model. The military has shown that providing the resources necessary to obtain accreditation from outside validators like NAEYC leads to better caregiver/child interactions, curriculum improvements, higher staff morale, and a variety of other quality improvements.

Support accreditation

Some states have adopted policies to support accreditation or provided incentives to meet voluntary state quality standards by, for example, establishing higher subsidy payment levels for accredited care or providing grants and technical assistance to help providers become

280 *See id.* at 18-20.

281 *See id.* at 17.

282 *See* Office of Inspector General, U.S. Department of Health and Human Services, Nationwide Review of Health and Safety Standards at Child Care Facilities 7-10 (1994). This report was based on unannounced site visits in Missouri, Nevada, North Carolina, South Carolina, and Wisconsin, as well as earlier HHS and GAO studies of state enforcement of child care standards. *See id.* at 3-5.

283 *See id.* at 10-15.

284 The GAO found, for example, that the number of states reporting that they conducted visits two or more times a year approximately doubled for all provider types between 1992 and 1999. *See* GAO 2000, *supra* note 272, at 18-20.

285 *See, e.g.*, Sharon L. Kagan & Nancy E. Cohen, The Quality 2000 Initiative, Not by Chance: Creating an Early Care and Education System for America's Children (Abridged Report), at Part Two (1997).

286 *See generally* 42 U.S.C. § 9836(d)(4) (1999); Family and Community Partnerships, 45 C.F.R. § 1304(c) (1999).

287 *See* Blank & Poersch, *supra* note 264, at 78. In addition, federal law requires that providers who receive CCDBG funds have an open door policy for parents. *See* 42 U.S.C. § 9858c(c)(2)(B) (1999).

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accredited.[288] In 1999, Florida enacted a major child care bill that, among other things, created incentives for centers to seek accreditation (including higher reimbursement rates for accredited providers of subsidized care and property tax exemptions for accredited providers).[289] In 1997, Delaware allocated funds for challenge grants to providers to meet accreditation standards.[290] Nationwide, however, relatively few centers are accredited; for example, less than 8 percent of child care centers across the United States have been accredited by NAEYC,[291] compared with 95 percent of military CDCs.[292] *Following the military's lead, states should make more resources available to assist providers in going beyond compliance with licensing requirements to meet higher accreditation requirements or other quality standards that exceed the mandatory standards.*[293]

c. Increase Staff Compensation and Improve Staff Training, and Link Compensation Increases to the Achievement of Training Milestones.

The civilian child care workforce is poorly compensated, lacks access to training, and is prone to high turnover rates that undermine the quality of care. For example, the *average* wage for a caregiver in a child care center in 1998 was $7.13 an hour,[294] or $7.40 in 2000 dollars—below the nearly $8 an hour *entry-level* wage for a military CDC caregiver with just a high school degree, who, within two years, receives an increase to nearly $10 an hour.[295] As for training, although all states currently have regulatory requirements for child care training and education, they vary widely and public funding for training is often very limited.[296] Unlike the military, thirty-one states do not require that child care workers receive any training before they can care for children in child care centers, and forty require no pre-service training for family child care providers.[297] Of the states that require ongoing training, only three require at least twenty-four hours a year for child care center teachers, as the military does, and none require that much for family child care providers.[298] Poor training and compensation have contributed to high turnover among civilian caregivers.[299]

The military has shown how these problems can be addressed effectively: provide training to establish and maintain core competency, and use training and curriculum specialists to continually improve staff training and development as well as curriculum. In addition, develop a base rate of compensation that is comparable to that of other individuals with similar training, seniority, and experience, and link increases in staff compensation to the completion of specific training milestones as well as greater educational attainment. The returns on this investment in the military child care system have benefited the children as well as the workers who care for them: improved training and compensation of child care providers has translated directly into more professional caregiving and a more stable workforce.[300]

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288 *See* Groginsky, *supra* note 105, at 26-29.

289 *See* Blank & Poersch, *supra* note 264, at 42.

290 *See* Blank & Adams, *supra* note 276, at 44.

291 *See Partnerships*, *supra* note 117.

292 *See* Interview with Linda Smith, *supra* note 57.

293 There are other accreditation systems in addition to NAEYC's. The National Child Care Association has a National Early Childhood Program Accreditation that accredits licensed child care and pre-school programs; the National School-Age Care Alliance accredits school-age programs; and the National Association of Family Child Care accredits family child care homes.

294 *See supra* note 256 and accompanying text.

295 *See* text accompanying *supra* notes 122-129. Moreover, caregivers with some experience can receive as much as $12.71 an hour; child care center employees in supervisory positions can receive even more. Military CDC child care workers also receive fringe benefits equal to about 22 percent of their salaries, and their salaries are subject to annual inflation adjustments. *See* Lucas, *supra* note 129.

296 *See* Groginsky, *supra* note 105, at 9.

297 *See* Center for Career Development in Early Care and Education at Wheelock College, *Child Care Licensing: Training Requirements for Roles in Child Care Centers and Family Child Care: 1999 Summary Sheet* (1999).

298 *See id.* at Table 1, Table 3.

299 *See* Worthy Work, Unlivable Wages, *supra* note 255, at 18.

300 Although military and civilian turnover rates are currently comparable, almost all of the military's turnover is due to the fact that 75 percent of child care staff are spouses of military members who are frequently transferred. *See Frequently Asked Questions*, *supra* note 19.

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It is important to note that the military has taken this approach not only for the CDCs and school-age programs, which it runs itself, but also for family child care homes, in which the providers are private individuals caring for children in their own homes. Adjustments have been made to reflect the different settings—training and curriculum specialists are not placed in homes, for example—but the training the military requires of and provides to FCC providers is comparable to the training it requires of CDC workers. A more difficult issue has been addressing the compensation of FCC providers, especially since the need to meet military standards (for example, by serving no more than three infants) has a very real effect on the cost—and accordingly on any profit a family child care provider can realize. In addition to the indirect subsidy the military gives FCCs, commanders have the authority to provide a direct cash subsidy (in effect, a compensation subsidy) to address this issue and to provide an incentive for the expansion of family child care homes. Although the RAND analysts found this approach to be underutilized,[301] it is currently being used with greater frequency and effectiveness by three of the Services.[302]

Increase training

Some states have recently strengthened their training requirements. For example, in 1999, Florida revised its licensing regulations to require all child care center directors to obtain a director's credential and increased the required training for family child care providers from three to thirty hours and for child care center workers from thirty to forty hours.[303] As funds have become available to states under the Child Care and Development Block Grant to improve child care quality, many states have expanded training and education opportunities for child care professionals.[304] *More states should follow their lead, using the military's training requirements as a model, including by ensuring both pre-service and annual refresher training for center-based, school-age, and family child care providers.*

Use training specialists

Some states have begun to explore creative programs to use specialists to improve training and quality of care, somewhat like the military's use of training and curriculum specialists. For instance, in 1999, Kansas provided funds for consultants to help organize an initiative devoted to developing continuing education units for early care and education, developing a training system for child care providers, and establishing core competencies and a career ladder.[305] In 1998, Iowa hired six family child care home consultants, who work through the resource and referral agencies in the state to improve the quality of family child care.[306] *Placing training and curriculum specialists in resource and referral agencies is less costly than putting them in every center, as the military has done, and a good way for states to make them available to help both centers and family child care homes improve training and quality of care.*

Improve compensation

Some states also have begun developing policies to directly address compensation for child care providers. A notable example is North Carolina's Child Care WAGE$ project, which provides salary supplements to trained providers every six months that they remain in the same child care program, and its Teacher Education and Compensation Helps (TEACH) initiative, which provides scholarships to providers seeking a CDA credential or a degree

301 *See* Zellman & Johansen, *supra* note 31, at 135-141.

302 *See* Interview with Linda Smith, *supra* note 85. With the development of additional CDCs on military installations now at near-capacity, commanders are expected to make even wider use of this option. *See* Smith, *supra* note 20.

303 *See* Blank & Poersch, *supra* note 264, at 77.

304 *See id.* at 10. The Child Care and Development Block Grant includes a 4 percent set-aside for provider training, education, and technical assistance. *See* 42 U.S.C. § 9858e (1999). Some states are using these funds for such activities as the creation and implementation of career development and credentialing plans, scholarships for child care providers seeking further credentials, and specialized training for providers in school-age programs and infant and toddler programs. *See* Groginsky, *supra* note 105, at 10; National Child Care Information Center, Child Care and Development Block Grant Report of State Plans for the Period 12/1/97 to 9/30/99 (1998).

305 *See* Blank & Poersch, *supra* note 264, at 52.

306 *See* Blank & Poersch 1998, *supra* note 274, at 26.

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and either a one-time bonus or salary increase upon completion of the program.[307] In North Carolina, the TEACH Health Insurance Program also covers part of the cost of health insurance for individuals working in child care programs with staff members participating in TEACH.[308] *More states should use the military model to develop similar compensation strategies that, for example, link increased training to higher salaries (with benefits) and include direct subsidy of family day care homes. As part of this process, and to build support for it, states should study and publicize the extent to which child care workers and family day care providers currently receive far less than other, comparable service providers in their communities.*

Lesson # 4:
Keep Parent Fees Affordable Through Subsidies.

The military CDC system keeps child care affordable through the use of a sliding schedule of fees based on parent income, combined with an allocation of public resources to cover the remaining costs. As a result, the average weekly fee paid by military families for center-based care is significantly lower than the average weekly fee paid by civilian families for center-based care of comparable quality.[309]

Here too, there are lessons for civilian child care. Currently, a patchwork array of government measures assists some families in meeting their child care expenses. The states provide a variety of forms of child care assistance, including, in over forty states, state-funded pre-kindergarten programs.[310] Through the Child Care and Development Block Grant[311] and the Temporary Assistance to Needy Families program,[312] the federal government provides funds to states to subsidize child care for low-income families through both grants to providers and vouchers to parents. The federal Head Start program provides comprehensive pre-kindergarten services to low-income or disabled children ages three to five,[313] and from birth to age three though Early Head Start.[314] The federal Dependent Care Tax Credit (DCTC),[315] as well as child and dependent care tax provisions in many states,[316] help families at a range of income levels meet their child care expenses by offsetting a portion of those expenses against their tax liability.

These policies, however, are not adequate. The CCDBG, for example, reaches only 15 percent of children eligible under state income limits and only 10 percent of children potentially eligible under federal guidelines.[317] The federal DCTC has eroded in value over time and, because it is not refundable, provides little or no benefit for the lowest-income families with no or low tax liability against which to apply the credit.[318] State child and dependent care tax provisions also are often inadequate; only nine states offer a refundable credit and no

107 *See* Groginsky, *supra* note 105, at 16-18 (describing TEACH and WAGE$, as well as other state initiatives that address wages and benefits); Blank & Poersch, *supra* note 264, at 49-50, 54-55 (describing WAGE$ and TEACH).

108 *See* Groginsky, *supra* note 105, at 17.

109 *See supra* note 200 and accompanying text. Although the military does not generally set fees for FCC homes, the provision of direct cash subsidies to FCCs has reduced the cost to parents of such care as well, especially since providers who receive such subsidies must agree to charge parents according to fees set by the installation commander. *See supra* notes 192-97 and accompanying text.

110 *See* Karen Schulman et al., Children's Defense Fund, Seeds of Success: State Prekindergarten Initiatives 1998-1999 11 (1999).

111 *See* 42 U.S.C. §§ 9858 *et seq.* (1999).

112 *See* 42 U.S.C. § 606 (1999).

113 *See* 42 U.S.C. §§ 9801 *et seq.* (1999).

114 *See* 42 U.S.C. § 9840a (1999).

115 *See* 26 U.S.C. § 21 (1999).

116 *See* Janice Steinschneider et al., National Women's Law Center, Making Care Less Taxing: Improving State Child and Dependent Care Tax Provisions (1998).

117 *See* Administration for Children and Families, *supra* note 262.

118 *See* National Women's Law Center, *Tax Relief for Employed Families: Improving the Dependent Care Tax Credit* 5-6 (2000). At best, the DCTC reimburses families for only 30 percent of child care expenses up to $2,400 for one child, or of up to $4,800 for two or more children. *See* 26 U.S.C. § 21.

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state offers as large a credit to as broad a population as the federal DCTC.[319] Head Start currently serves only about half of eligible preschool-age children.[320] In most state pre-kindergarten programs, the amount of funding per pupil is too low to guarantee a comprehensive, high-quality, part-day program.[321]

Expand subsidies through sliding fee scales and other mechanisms

Even when families receive subsidies, child care expenses remain a heavy burden in states that require high co-payments. As previously described, a family of three in Oregon with annual income at 150 percent of the poverty level ($20,820) pays more than 20 percent of its income in child care co-payments. Experts recommend that low-income families above the poverty level should be required to pay no more than 10 percent of their income for child care,[322] approximately what military families pay. Yet, in 1999, ten states required a family of three at 150 percent of the federal poverty level receiving a child care subsidy to pay more than 10 percent of its gross income in child care co-payments. In an additional nine states, a family at this income level was eligible for no child care subsidy at all.[323] *Policy makers, at both the federal and state levels, should follow the military's example in making significant public resources available—as well as using the mechanisms it has used to distribute these resources—to help subsidize care for families who cannot afford to pay the full cost of good child care.*

An aspect of military child care that should be further debated on the civilian side is the commitment to offering some fee subsidy to individuals at all income levels, to ensure that the system is a universal one and not one just for low-income families. This commitment has its trade-offs, which for the military have included a decrease in the supply of care that might otherwise have been provided.[324] It also has its benefits, however, in the level and extent of parent satisfaction with and support for the system.[325] The patchwork civilian child care system, in contrast, by and large focuses subsidy assistance to parents at the lowest income levels. If a more universal civilian system is seen as desirable, it is important to develop the mechanisms needed to deliver such a system and to factor its cost into the resources needed.

Lesson # 5: Expand the Availability of All Kinds of Care By Continually Assessing Unmet Need and Taking Steps to Address It.

A key to the military's overall progress in meeting child care demand was the MCCA's requirement that DoD assess unmet need and produce a plan for increasing child care capacity to meet the demand. Moreover, the military has recognized that a successful child care system must be a comprehensive one that includes an adequate supply of slots in child care centers, family child care, and programs for school-age youth, as well as resource and referral agencies to assist parents in locating care. Although demand still far exceeds supply in the military system, DoD has dramatically increased the capacity of its child care system, including by building new centers and expanding old ones, expanding its FCC and before- and after-school programs, and increasing the role of resource and referral agencies. The Defense Department is now working to expand its capacity in all areas by developing part-

319 *See* Steinschneider et al., *supra* note 316 at 27-32; National Women's Law Center, *Recent Changes in State Child and Dependent Care Tax Provisions: Tax Year 2000* (2000).

320 *See* Children's Defense Fund, Key Facts 128 (1999).

321 *See* Schulman *et al.*, *supra* note 310, at 18.

322 *See* Blank & Poersch, *supra* note 284, at 23.

323 *See id.* at 26-27.

324 Even today, with the supply of care on military installations reaching capacity, DoD has stated it will not trade off quality or its universal subsidy to expand supply. *See* Smith, *supra* note 20.

325 *See* Interview with Linda Smith, *supra* note 97.

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nerships with child care providers in the local communities surrounding military installations that will both improve the quality of care they provide and guarantee slots for military families at reasonable cost.

As shown above, a shortage of child care and school-age programs is a serious problem outside of the military as well. A 1997 GAO study, for example, found that in Chicago, the supply was sufficient to meet only 16 percent of the demand for infant care, and 23 percent of the demand for school-age care.[326] Families in low-income communities often have particular difficulty meeting their child care needs.[327] Moreover, many states lack statewide resource and referral services[328] or resource and referral networks with funding and paid staff,[329] key to helping families find care.

Develop and implement a concrete plan to increase capacity

Here again, the military's experience is instructive for states and localities seeking to expand child care capacity. To be sure, some states and cities have already moved to address supply problems, including by assisting with the costs of borrowing for construction and renovation of child care facilities; using a variety of funding sources to expand and improve prekindergarten facilities; providing direct grants to family care providers to expand care for categories of children for whom appropriate programs are in short supply (such as infants, children with special needs, or children receiving subsidies); funding state-wide resource and referral services; and providing grants and loans to child care centers for construction, renovation and expansion, sometimes through public-private partnerships.[330] The military's experience shows that it is important for such efforts to take into account all the different components of a good child care system, and not, for example, to focus exclusively on center-based care or neglect school-age programs. It also suggests that it is possible to expand capacity over time, by applying the experience in one area to the others and adapting the techniques used in one area to different contexts. Indeed, *the military experience demonstrates that an important part of maintaining public support for—and increased investment in—child care is to measure unmet demand and then develop and make public a plan for expanding capacity, with specific goals and timetables for making progress.*

Realistically assess tradeoffs

The military's experience is instructive in another way as well. While efforts to improve civilian child care generally focus on expanding capacity first, rather than enhancing quality and affordability, the military deliberately chose to focus first on quality and affordability even though this slowed progress on supply. The rationale was simple: to develop a system that would promote children's healthy development and learning, for the benefits that it would deliver over the longer term. Noting that internal surveys show that 50 percent of military children eventually enter the military or seriously consider doing so, DoD recognized that it "must educate them now or educate them later, and later would be far more expensive."[331] A system that cared about children's welfare and was affordable would also benefit the military's current workforce—their parents. These considerations were seen as more important than serving every family at the outset, although that is a goal the system is on its way to fulfilling

326 *See* GAO 1997, *supra* note 245, at 9.

327 *See* U.S. Department of Education, The Condition of Education: 1993 372, Table 48-3 (1993); GAO 1997, *supra* note 245, at 15. Child care may be especially hard to find in states that reimburse providers of subsidized care at low rates. While many states have recently improved their provider reimbursement rates, about one third still base these rates on out-of-date market surveys of child care fees. *See* Blank & Poersch, *supra* note 264, at 30. Connecticut is most egregious on this count, basing its reimbursement rates on a 1991-1992 market rate survey. *See id.* at 34.

328 *See* Diane Adams et al., Making Child Care Work: A Study of Child Care Resources and Referral in the United States — Major Findings 10 (rev. ed. 2000).

329 *See* Memorandum from Yasmina Vinci, National Association of Child Care Resource and Referral Agencies (April 3, 2000) (on file with National Women's Law Center).

330 *See* Children's Defense Fund, *supra* note 320, at 59-60; Culkin et al., *supra* note 105, at 9-12; National Child Care Information Center, *Child Care Partnership Project* (visited Mar. 22, 2000) <http://nccic.org/ccpartnerships/home.htm>.

331 Interview with Linda Smith, *supra* note 57.

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as well. The military's experience makes a strong case for policy makers in the civilian world to focus greater attention on quality and affordability over supply as well.

Lesson # 6:
Commit the Resources Necessary to Get the Job Done.

Improving the quality, affordability, and supply of child care is a costly proposition. While the military child care system does not yet meet all of its goals, sufficient funds have been made available to enable DoD to achieve tremendous gains in each of these areas. Through increased Congressional appropriations and increased allocations from within DoD resources, the funds available for the military child care program have been climbing dramatically in recent years. From an appropriation of about $90 million pre-MCCA to $352 million in FY 2000, the total of appropriated funds alone has nearly quadrupled.

It is difficult to quantify the total public investment in child care on the civilian side, especially since there are so many different funding streams to consider at the federal, state, and local levels, including subsidy programs, early education programs, tax credits, and other government programs. It is equally challenging to quantify the total need of American families for child care. It is clear, however, that subsidized, high-quality child care is not being provided to anything close to 58 percent of all American families who need child care—the percentage of child care need that is currently met by the military system—especially if the universe of those who need care is defined, as it is in the military, to include all working parents regardless of income.[332] In fact, federal programs aimed at low-income families serve only a fraction of the children they are intended to serve. As stated above, CCDBG subsidizes only one in ten federally eligible children,[333] and Head Start serves only about half of eligible preschool-aged children.[334]

Increase the public investment

In the absence of a sufficient public investment, the system is kept afloat, in effect, by a series of hidden sacrifices: by poorly-paid caregivers who are subsidizing the system when they forgo decent wages and benefits; by parents who are spending a high proportion of their income on child care and/or making do with poor-quality, inadequate arrangements; by their children, who are incurring the long-term developmental consequences of poor quality care; and by employers who are bearing the costs of an unstable workforce and absent and distracted workers worrying about their children's care. *An increased investment in the availability of high-quality, affordable child care would reduce these costs in the current system, and more than pay for itself in the end.*

332 Nor is over half the overall cost of such care provided by the government, as it is in the military.
333 *See* Administration for Children and Families, *supra* note 262.
334 *See* Children's Defense Fund, *supra* note 320.

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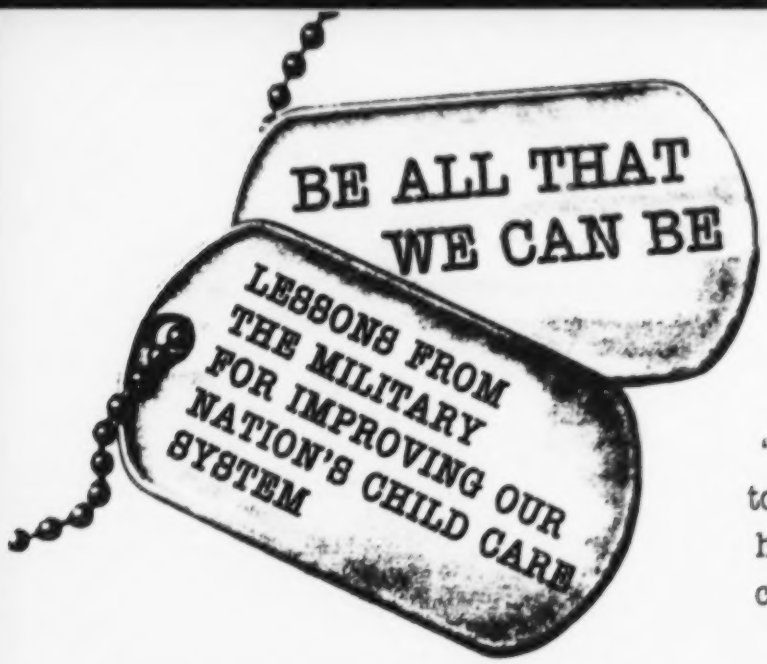
C. CONCLUSION

Be all that we can be

Taken together, the lessons from the military's child care experience convey a hopeful message for those seeking to improve child care across the United States. Just as policy makers were prodded into action a decade ago by the exposure of serious problems in military child care, policy makers today should see the importance of according the same priority to civilian child care and allocating the resources that are needed to address it. If a child care system as deficient as that confronting the military a decade ago could be turned around so dramatically—and by an institution as inherently conservative as the military—then surely similar successes can be achieved in the civilian world, by employing and adapting the specific techniques used by the military to accomplish its turnaround. In short, if we really want to "be all that we can be," we must redouble the nation's commitment to and investment in child care, and apply the tools that have proved effective in expanding access to high-quality, affordable child care in the Armed Services more broadly to civilian child care. Then we can celebrate with our children the same positive results.



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"The best chance a family has to be guaranteed affordable and high-quality [child] care in this country is to join the military."

THERE IS SOME TRUTH TO THIS COMMENT from a leading child care advocate. Too often, across the United States today, high-quality child care is unaffordable or simply not available to families who need it. Ten years ago, the situation in the military was at least as bad, if not worse: the demand for child care had surged as a result of a changing military workforce; thousands of children were on waiting lists for care; much of the care was of poor quality; caregivers lacked training and were so poorly compensated they did not stay in the field; parent fees could not support the changes that were needed; and resource allocations from public funds were not sufficient to make up the difference.

But, as *Be All That We Can Be* demonstrates, the military achieved a remarkable transformation of its child care system, and its experience over the past decade provides an excellent model for the very real reforms that need to be made in civilian child care policy and practice as well. The military now operates a comprehensive child care system that includes center-based care, family child care homes, before- and after-school programs, and resource and referral services to assist parents in finding care. Basic standards have been applied and are rigorously enforced, and over 95 percent of military child care centers meet the higher standards necessary for outside accreditation. Caregivers receive systematic training and increased compensation linked to their training. Subsidies help parents afford the care they need. And the system is serving a steadily increasing proportion of military personnel who need it. *Be All That We Can Be* tells the story of the military's successes and offers valuable lessons for policy makers, child care administrators, advocates, parents, providers, and others on how similar improvements can be made in civilian child care.

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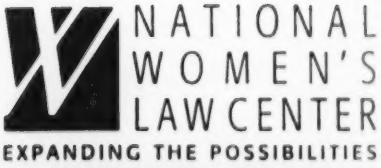
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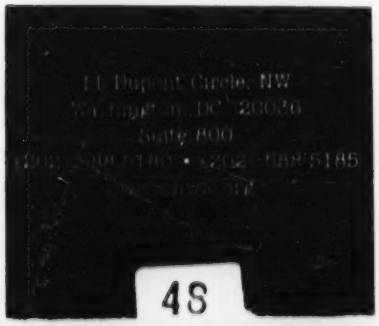
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